AMERICAN MEDICAL ASSOCIATION

HOUSE OF DELEGATES

ST. LOUIS, MAY 22, 1922

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. They are submitted in confidence to the Delegates
ill be official only after they, or some modification or
ule for them, have been presented to the House of
tes.

AMERICAN MEDICAL ASSOCIATION

HAND BOOK FOR THE HOUSE OF DELEGATES

General Officers, Standing and Special Committees, Members of the House, Official Order of Business, Reports for 1922 and Constitution and By-Laws and Standing Rules

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ST. LOUIS, MO.
JUNE 22-26, 1922

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* Died Oct. 21, 1921.

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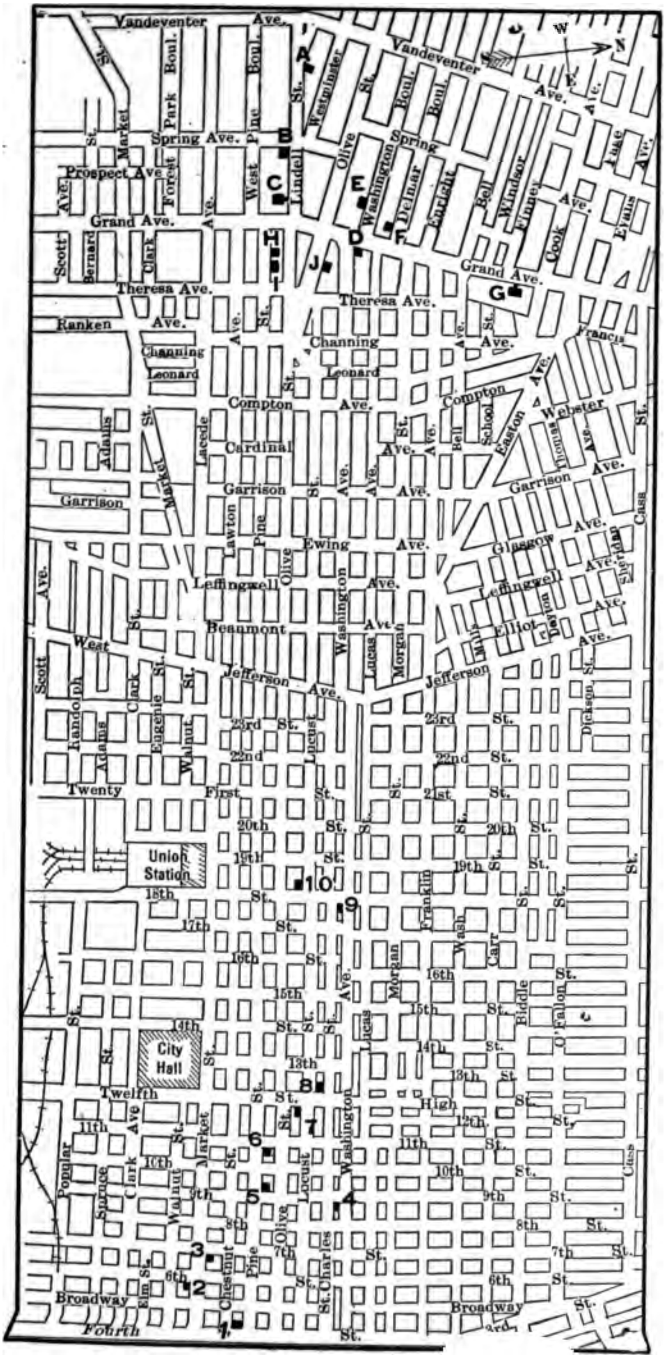
Vandeventer Ave.
Park Boul.
Pine Boul.
Spring Ave.
Prospect Ave.
Market St.
Forest Ave.
West Pine
Lindell
Grand Ave.
Scott
Bernard
Clark
Theresa Ave.
Ranken Ave.
Channing
Leonard
Compton
Cardinal
Garrison
Lacede
Lawton
Pine
Olive
Ewing
Leffingwell
Beaumont
Washington
Lucas
Morgan
West
Jefferson Ave.
Randolph
Adams
Eugenie
Walnut
Locust
23rd St.
22nd St.
Twenty First St.
21st St.
20th St.
19th St.
18th St.
17th St.
16th St.
15th St.
14th St.
13th St.
12th St.
11th St.
10th St.
9th St.
8th St.
7th St.
6th St.
Union Station
City Hall
Twelfth
Franklin
Wash
Carr
Biddle
O'Fallon
Cass
High
Popular
Spruce
Chestnut
St. Charles
Elm St.
Broadway
Fourth
Westminster
Olive
Washington
Delmar
Enright
Bell
Windsor
Finney
Cook
Evans
Easton
School
Thomas
Webster
Francis
Glasgow Ave.
Sheridan
Dayton
Elliot
Mills
Dickson St.
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Odeon Theater (G)
Planters' Hotel (1)
Sheldon Memorial Hall (E)
St. Louis Medical Society Bldg. (I)
St. Louis University Law School Auditorium (C)
St. Peter's Parish House (B)
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Third Baptist Church (D)
Union Methodist Episcopal Church (F)
Warwick Hotel (7)

MEETING PLACES AND HOTEL HEADQUARTERS

The following have been designated as section hotel headquarters and as meeting places * for the St. Louis Session—May 22 to 26:

HOUSE OF DELEGATES: *St. Louis Medical Society Building* (I).

GENERAL MEETING: *Odeon Theater* (G).

PRACTICE OF MEDICINE: Statler (4). *Odeon Theater* (G).

SURGERY, GENERAL AND ABDOMINAL: Jefferson (8). *Third Baptist Church* (D).

OBSTETRICS, GYNECOLOGY AND ABDOMINAL SURGERY: Claridge (10). *Third Baptist Church* (D).

OPHTHALMOLOGY: Planters (1). *Sheldon Memorial Hall* (E).

LARYNGOLOGY, OTOLOGY AND RHINOLOGY: Marquette (9). *Sheldon Memorial Hall* (E).

DISEASES OF CHILDREN: American (3). *Odeon Theater* (G).

PHARMACOLOGY AND THERAPEUTICS: American Annex (2). *Odeon Theater* (G).

PATHOLOGY AND PHYSIOLOGY: American Annex (2). *Odeon Theater* (G).

STOMATOLOGY: Warwick (7). *St. Peter's Episcopal Church Parish House* (B).

NERVOUS AND MENTAL DISEASES: Majestic (6). *St. Louis University Law School Auditorium* (C).

DERMATOLOGY AND SYPHILOLOGY: Majestic (6). *Union Methodist Episcopal Church* (F).

PREVENTIVE MEDICINE AND PUBLIC HEALTH: Warwick (7). *Musicians' Hall* (H).

UROLOGY: Maryland (5). *Union Methodist Episcopal Church* (F).

ORTHOPEDIC SURGERY: Jefferson (8). *St. Louis University Law School Auditorium* (C).

GASTRO-ENTEROLOGY AND PROCTOLOGY: Maryland (5). *Musicians' Hall* (H).

MISCELLANEOUS (MEETING ON ANESTHESIA): *St. Peter's Episcopal Church Parish House* (B).

GENERAL HEADQUARTER: SCIENTIFIC EXHIBIT, REGISTRATION BUREAU, COMMERCIAL EXHIBIT, INFORMATION BUREAU AND BRANCH POSTOFFICE: *Moolah Temple* (A).

* Meeting places in italics.

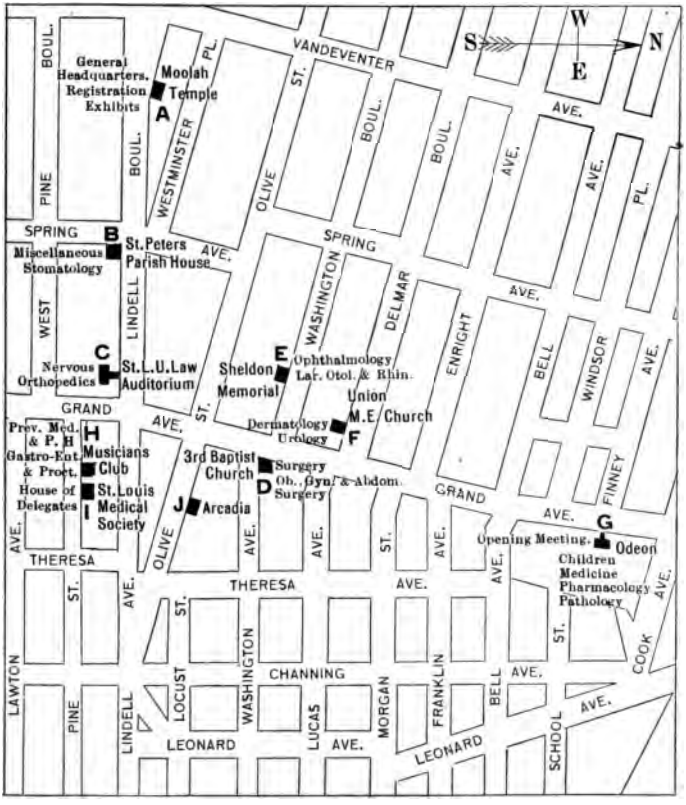

Diagram of central section of city showing headquarters and meeting places.

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Chairman, Peter Bassoe, Chicago; Vice Chairman, Walter F. Schaller, San Francisco; Secretary, James B. Ayer, Boston. Executive Committee: Archibald Church, Chicago; Arthur S. Hamilton, Minneapolis; Peter Bassoe, Chicago.

DERMATOLOGY AND SYPHILOLOGY

Chairman, Ernest Dwight Chipman, San Francisco; Vice Chairman, Harry G. Irvine, Minneapolis; Secretary, Harold Newton Cole, Cleveland. Executive Committee: Oliver S. Ormsby, Chicago; Walter J. Highman, New York; Ernest Dwight Chipman, San Francisco.

PREVENTIVE MEDICINE AND PUBLIC HEALTH

Chairman, S. W. Welch, Montgomery, Ala.; Vice Chairman, Bernard W. Carey, Boston; Secretary, W. S. Leathers, University, Miss. Executive Committee: James A. Hayne, Columbia, S. C.; John McLean, Philadelphia; S. W. Welch, Montgomery, Ala.

UROLOGY

Chairman, James A. Gardner, Buffalo; Vice Chairman, A. J. Crowell, Charlotte, N. C.; Secretary, Herman L. Kretschmer, Chicago. Executive Committee: William E. Lower, Cleveland; Richard F. O'Neil, Boston; James A. Gardner, Buffalo.

ORTHOPEDIC SURGERY

Chairman, H. Winnett Orr, Lincoln, Neb.; Vice Chairman, W. C. Campbell, Memphis, Tenn.; Secretary, H. B. Thomas, Chicago. Executive Committee: George W. Hawley, New York; Melvin S. Henderson, Rochester, Minn.; H. Winnett Orr, Lincoln, Neb.

GASTRO-ENTEROLOGY AND PROCTOLOGY

Chairman, H. W. Soper, St. Louis; Vice Chairman, J. Rawson Pennington, Chicago; Secretary, Franklin W. White, Boston. Executive Committee: Frank Smithies, Chicago; Louis J. Hirschman, Detroit; H. W. Soper, St. Louis.

MISCELLANEOUS TOPICS

MEETING ON ANESTHESIA

Chairman, Isabella C. Herb, Chicago; Vice Chairman, David E. Hoag, Pueblo, Colo; Secretary, F. Hoeffer McMechan, Avon Lake, Ohio.

NOTICE

The House of Delegates will meet at 10 a. m. on Monday, May 22, 1922, in the St. Louis Medical Society Building, 3525 Pine Street, St. Louis.

The Committee on Credentials will meet in the hall adjoining the meeting place of the House of Delegates, at 9 a. m., on Monday, May 22, 1922. Credentials should be presented to the Committee as early as possible, so that the official roll of the House may be made up. The Committee on Credentials will also meet preceding each subsequent meeting of the House of Delegates.

Delegates should present properly executed credentials, signed by the president and secretary of the constituent association or section which they represent. Alternates presenting credentials should see that the delegates whose places they take have signed the alternate authorization.

Rooms adjoining the meeting place of the House of Delegates have been provided for the use of committees. The reference committees are urged to meet in these rooms and to announce the time of their meetings, that those interested in matters referred may be able to appear before the committees. Here will be found stenographers and typewriters who will be at the service of the members of the House of Delegates for preparing official reports and writing resolutions and motions.

In accordance with a resolution adopted by the House of Delegates at the Boston Session, 1906, all reports of committees, resolutions, written motions, etc., must be in duplicate, one copy for preservation in the minutes, and the other to go to the committee to which the matter is referred. Both copies should be handed to the Secretary at the time the matter is presented. Such copies can easily be secured by requesting the typewriter to make a carbon copy at the time the report is written.

House of Delegates, 1922

The following is a list of the holdover and newly elected members of the House of Delegates who have been reported in time to be included:

ALABAMA—2

S. W. Welch.....Montgomery
J. D. Heacock.....Birmingham

ARIZONA—1

John W. Flinn.....Prescott

ARKANSAS—2

George S. Brown.....Conway
William R. Bathurst.....Little Rock

CALIFORNIA—4

Albert Soiland.....Los Angeles
H. Bert Ellis (Deceased).....Los Angeles
John H. Graves.....San Francisco
.....

COLORADO—2

W. A. Jayne.....Denver
L. H. McKinnie*.....Colorado Springs

CONNECTICUT—2

Walter Ralph Steiner.....Hartford
John Edward Lane*.....New Haven

DELAWARE—1

H. J. Stubbs.....Wilmington

DISTRICT OF COLUMBIA—1

William Gerry Morgan.....Washington

FLORIDA—1

John S. Helms.....Tampa

GEORGIA—2

W. C. Lyle.....Atlanta
.....

IDAHO—1

.....

* Term begins with this session of the House.

ILLINOIS—9

J. W. Van Derslice.....Oak Park
C. E. Humiston.....Chicago
R. L. Green.....Peoria
H. P. Beirne.....Quincy
.....
.....
.....
.....
.....

INDIANA—3

J. Rilus Eastman.....Indianapolis
Albert E. Bulson, Jr.*.....Fort Wayne
George F. Keiper*.....Lafayette

IOWA—3

J. C. Rockafellow.....Des Moines
.....
.....

KANSAS—2

.....
.....

KENTUCKY—3

W. W. Richmond.....Clinton
L. S. McMurtry.....Louisville
Irvin Abell*.....Louisville

LOUISIANA—2

W. H. Seemann.....New Orleans
W. H. Block*.....New Orleans

MAINE—1

Bertram L. Bryant*.....Bangor

MARYLAND—2

T. S. Cullen.....Baltimore
Randolph Winslow*.....Baltimore

MASSACHUSETTS—5

H. G. Stetson.....Greenfield
C. F. Mongan.....Somerville
J. F. Burnham.....Lawrence
F. B. Lund*.....Boston
E. F. Cody*.....New Bedford

MICHIGAN—4

A. W. Hornbogen.....Marquette
Guy L. Connor.....Detroit
J. D. Brook.....Grandville
F. C. Warnshuis.....Grand Rapids

MINNESOTA—2

W. H. Magie.....Duluth
J. W. Bell *.....Minneapolis

MISSISSIPPI—2

John W. Barksdale.....Winona
.....

MISSOURI—4

R. E. Schlueter.....St. Louis
J. Curtis Lyter.....St. Louis
.....
.....

MONTANA—1

Creswell T. Pigot *.....Roundup

NEBRASKA—2

A. D. Dunn.....Omaha
.....

NEVADA—1

J. LaRue Robinson *.....Reno

NEW HAMPSHIRE—1

D. E. Sullivan *.....Concord

NEW JERSEY—3

Henry A. Cotton.....Trenton
Edward Guion * .....Atlantic City
George E. Reading *.....Woodbury

NEW MEXICO—1

H. A. Miller.....Clovis

NEW YORK—11

James F. Rooney.....Albany
Frederic E. Sondern.....New York
William F. Campbell.....Brooklyn
Grover W. Wende.....Buffalo
Thomas H. Halsted.....Syracuse
Arthur J. Bedell *.....Albany
Thomas C. Chalmers *.....Forest Hills
E. Eliot Harris *.....New York
Edward Livingston Hunt *.....New York
J. Richard Kevin *.....Brooklyn
Grant C. Madill *.....Ogdensburg

NORTH CAROLINA—2

J. F. Highsmith.....Fayetteville

.....

NORTH DAKOTA—1

E. A. Pray.....Valley City

OHIO—6

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OKLAHOMA—2

L. J. Moorman.....Oklahoma City
J. M. Byrum *.....Shawnee

OREGON—1

Joseph A. Pettit.....Portland

PENNSYLVANIA—9

C. A. E. Codman.....Philadelphia
John B. McAlister.....Harrisburg
George A. Knowles.....Philadelphia
John D. McLean.....Harrisburg
Edward B. Heckel *.....Pittsburgh
Walter S. Stewart *.....Wilkes-Barre
William F. Bacon *.....York
Wilmer Krusen * .....Philadelphia
C. C. Cracraft *.....Claysville

RHODE ISLAND—1

Jesse E. Mowry.....Providence

SOUTH CAROLINA—1

Edgar A. Hines.....Seneca

SOUTH DAKOTA—1

.....

TENNESSEE—3

L. A. Yarbrough.....Covington
John A. Witherspoon *.....Nashville
L. L. Sheddan *.....Knoxville

TEXAS—5
Holman Taylor.....Fort Worth
M. F. Bledsoe.....Port Arthur
R. L. Ramey.....El Paso
.....
.....

UTAH—1
E. M. Neher.....Salt Lake City

VERMONT—1
F. T. Kidder.....Woodstock

VIRGINIA—3
Joseph T. Buxton.....Newport News
E. G. Williams*.....Richmond
Southgate Leigh* .....Norfolk

WASHINGTON—2
D. E. McGillivray.....Port Angeles
.....

WEST VIRGINIA—2
James R. Bloss.....Huntington
Henry P. Linsz*.....Wheeling

WISCONSIN—3
Rock Sleyster.....Wauwautosa
Horace M. Brown.....Milwaukee
Joseph F. Smith*.....Wausau

WYOMING—1
Earl Whedon.....Sheridan

ALASKA—1
.....

HAWAII—1
.....

ISTHMIAN CANAL ZONE—1
.....

PHILIPPINE ISLANDS—1
.....

PORTO RICO—1
Jacinto Avilés*.....San Juan

DELEGATES FOR SECTIONS

PRACTICE OF MEDICINE
Walter L. Bierring.....Des Moines

SURGERY, GENERAL AND ABDOMINAL
Hugh H. Trout.....Roanoke, Va.

OBSTETRICS, GYNECOLOGY AND ABDOMINAL SURGERY
George G. Ward, Jr.....New York

OPHTHALMOLOGY
C. D. Wescott.....Chicago

LARYNGOLOGY, OTOLOGY AND RHINOLOGY
Emil Mayer.....New York

DISEASES OF CHILDREN
Isaac A. Abt.....Chicago

PHARMACOLOGY AND THERAPEUTICS
Leonard G. Rowntree.....Rochester, Minn.

PATHOLOGY AND PHYSIOLOGY
D. J. Davis.....Chicago

STOMATOLOGY
E. S. Talbot.....Chicago

NERVOUS AND MENTAL DISEASES
Walter Timme.....New York

DERMATOLOGY
Howard Fox.....New York

PREVENTIVE MEDICINE AND PUBLIC HEALTH
John D. McLean.....Harrisburg, Pa.

UROLOGY
Carl L. Wheeler.....Lexington, Ky.

ORTHOPEDIC SURGERY
John Ridlon.....Chicago

GASTRO-ENTEROLOGY AND PROCTOLOGY
Alois B. Graham.....Indianapolis

GOVERNMENT SERVICES

United States Army.....Joseph F. Siler

United States Navy.....Charles M. Oman

United States Public Health Service...J. W. Schereschewsky

ORDER OF BUSINESS*

MONDAY, MAY 22—10 A. M.

1. Call to Order by the Speaker.
2. Preliminary Report of the Committee on Credentials.
3. Roll Call.
4. Presentation, Correction and Adoption of Minutes of the Seventy-Second Annual Session.
5. Report of Officers.
   (1) Speaker's Address and Appointment of Reference Committees.
   (2) President's Address.
   (3) President-Elect's Address.
   (4) Report of Secretary.
   (5) Report of Board of Trustees, including Reports of Treasurer and Auditor.
6. Reports of Standing and Special Committees:
   (1) Judicial Council.
   M. L. Harris, Illinois, Chairman.
   (2) Council on Health and Public Instruction.
   Victor C. Vaughan, District of Columbia, Chairman.
   (3) Council on Medical Education.
   Arthur D. Bevan, Illinois, Chairman.
   (4) Council on Scientific Assembly.
   J. Shelton Horsley, Virginia, Chairman.
7. New Business.
8. Reports of Reference Committees.

* The House of Delegates will adjourn at 12: 30 p. m. and reconvene at 3. This intermission will permit the Reference Committees to meet and act on subjects referred to them.

TUESDAY, MAY 23—9:30 A. M.

1. Roll Call.
2. Reading and Adoption of Minutes.
3. Supplementary Report of Committee on Credentials.
4. Report from Board of Trustees and the Councils.
5. Reports of Reference Committees:
   - (1) Reference Committee on Sections and Section Work.
   - (2) Reference Committee on Rules and Order of Business.
   - (3) Reference Committee on Medical Education.
   - (4) Reference Committee on Legislation and Political Action.
   - (5) Reference Committee on Hygiene and Sanitary Science.
   - (6) Reference Committee on Amendments to the Constitution and By-Laws.
   - (7) Reference Committee on Reports of Officers.
   - (8) Reference Committee on Miscellaneous Business.
6. Unfinished Business.
7. New Business. (See By-Laws, Chap. II, Sec. 2, p. 8.)
   (Wednesday meetings will be held subject to the action of the House of Delegates.)

THURSDAY, MAY 25—2 P. M.*

1. Supplementary Report of Committee on Credentials.
2. Roll Call.
3. Reading and Adoption of Minutes.
4. Election of Officers:
   - (1) President.
   - (2) Vice President.
   - (3) Secretary.
   - (4) Treasurer.
   - (5) Speaker, House of Delegates.
   - (6) Vice Speaker, House of Delegates.

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* See By-Laws, Chap. IV, Sect. 4, p. 10.

(7) Trustees.

Three to be elected to serve until 1925. The Trustees whose terms expire this year are: A. R. Mitchell, Lincoln, Neb.; D. Chester Brown, Danbury, Conn.; Oscar Dowling, Shreveport, La. The other members of the Board of Trustees are: W. T. Sarles, Sparta, Wis., 1923; Charles W. Richardson, Washington, D. C., 1923; Walter T. Williamson, Portland, Ore., 1923; Frank Billings, Chicago, 1924; Wendell C. Phillips, New York, 1924; Thomas McDavitt, St. Paul, 1924.

5. Nominations for Standing Committees by President, and Confirmation by the House of Delegates:

(1) Member of Judicial Council to succeed Randolph Winslow, Baltimore, for a term ending 1927. The other members of this Council are: William S. Thayer, Baltimore, 1923; M. L. Harris, Chicago, 1924; I. C. Chase, Fort Worth, Texas, 1925; J. N. Hall, Denver, 1926.

(2) Member of Council on Health and Public Instruction, to succeed W. B. Cannon, Boston, for a term ending 1927. The other members of this Council are: W. S. Rankin, Raleigh, N. C., 1923; Haven Emerson, New York, 1924; Milton Board, Louisville, Ky., 1925; Victor C. Vaughan, Chairman, Washington, D. C., 1926.

(3) Member of Council on Medical Education, to succeed William Pepper, Philadelphia, for a term ending 1927. The other members of this Council are: Arthur D. Bevan, Chicago, 1923; M. W. Ireland, U. S. Army, 1924; Ray L. Wilbur, Stanford University, Calif., 1925; S. W. Welch, Montgomery, Ala., 1926.

(4) Member of Council on Scientific Assembly, to succeed E. S. Judd, Rochester, Minn., for a term ending 1927. The other appointed members of this Council are: Roger S. Morris, Cincinnati, 1923; F. P. Gengenbach, Denver, 1924; J. Shelton Horsley, Richmond, Va., 1925; John E. Lane, New Haven, Conn., 1926.

6. Election of Honorary, Affiliate and Associate Fellows.
7. Selection of the Place and Fixing the Time for the 1923 Annual Session.
8. Supplementary Reports from Board of Trustees and Reference Committees.
9. Unfinished Business.
10. Adjournment.

Report of Officers

SECRETARY'S REPORT

To the Members of the House of Delegates of the American Medical Association:

The following report is submitted for 1921-1922:

MEMBERSHIP

The membership of the several constituent associations which is the membership of this Association, according to records in the Secretary's office on May 1, 1922, was 89,048. This is shown in the accompanying table which also indicates the increase and the decrease in the membership of each of the organizations.

FELLOWSHIP

The Fellowship of the Scientific Assembly of the American Medical Association on May 1, 1921, was 50,970. During the year from May 1, 1921, to May 1, 1922, 478 Fellows have died, 1,433 have resigned, 724 have been dropped from the roll as not eligible, 692 have been dropped for non-payment of Fellowship dues and the names of twelve have been removed from the roll on account of being reported "not found," making a total of 3,339 names to be deducted from the Fellowship roll. Of these discontinuances, 962 have been transferred from the Fellowship roster to the subscription list of THE JOURNAL. There have been added to the Fellowship roll 5,391 names. Of these 3,407 were transferred from the subscription list of the Association's publications. The Fellowship of the Association on May 1, 1922, was 53,022, a net increase of 2,052.

DEATH OF SPEAKER

Dr. Dwight H. Murray, Speaker of the House of Delegates, died suddenly at his home in Syracuse, N. Y., from valvular heart disease on Oct. 21, 1921, aged 60. He represented the Medical Society of the State of New York in this House of Delegates continuously from 1910-1920, when he was elected Speaker of the House. He was Vice President from 1916 to 1920.

ORGANIZATION OF CONSTITUENT ASSOCIATIONS

Constituent Association of	No. Counties in State	No. Component Societies in State Assn.	Number Counties in State Not Organized		No. Physicians in State (7th Ed. Directory)	Number Members of State Association		No. A. M. A. Fellows in State	No. Subscribers to Journal in State*
			1921	1922		1921	1922		
Alabama	67	67	.....	.....	2,405	1,683	1,667	469	302
Arizona	14	12	3	2	380	245	180	168	88
Arkansas	75	63	12	12	2,450	1,194	1,114	437	208
California	58	42	16	16	6,766	3,351	3,450	2,499	1,701
Colorado	63	36	27	27	1,817	896	1,045	667	349
Connecticut	8	8	.....	.....	1,729	1,019	1,083	708	393
Delaware	3	3	.....	.....	262	129	135	94	56
Dist. Columbia	.....	.....	.....	.....	1,689	567	570	374	253
Florida	54	31	23	23	1,281	577	580	302	252
Georgia	154	101	53	53	3,406	1,225	1,858	583	363
Idaho	44	26	18	18	553	250	313	144	116
Illinois	102	100	2	2	10,651	7,065	7,384	4,679	2,121
Indiana	92	90	2	2	4,446	2,420	2,444	1,348	649
Iowa	99	99	.....	.....	3,536	2,277	2,448	1,365	608
Kansas	105	67	38	38	2,550	1,639	1,632	865	387
Kentucky	120	114	6	6	3,323	2,142	2,158	744	309
Louisiana	64	41	23	23	2,001	1,124	1,076	758	278
Maine	16	15	1	1	1,105	667	748	367	139
Maryland[1]	23	21	2	2	2,364	1,274	1,291	827	592
Massachusetts[2]	14	14	.....	.....	5,959	3,798	3,944	2,692	1,151
Michigan	83	81	2	2	4,593	2,864	3,147	1,678	787
Minnesota	86	82	4	4	2,628	1,452	1,704	1,201	643
Mississippi	81	79	2	2	1,761	794	881	338	191
Missouri[1]	114	108	6	6	5,921	3,383	3,511	1,743	828
Montana	51	19	32	32	620	381	372	181	161
Nebraska	93	63	29	30	1,965	1,068	1,077	688	418
Nevada	17	3	14	14	147	91	99	60	34
New Hampshire	10	10	.....	.....	641	520	524	291	80
New Jersey	21	21	.....	.....	3,260	1,895	2,108	1,441	681
New Mexico	29	14	15	15	529	286	298	126	92
New York	62	61	1	1	16,284	8,916	9,270	5,763	3,162
North Carolina	100	82	18	18	2,236	1,636	1,412	563	415
North Dakota	53	51	2	2	556	455	415	272	113
Ohio	88	87	1	1	8,092	4,556	5,058	2,518	1,370
Oklahoma	77	66	11	11	2,622	1,374	1,350	702	281
Oregon	36	34	2	2	1,145	616	714	300	252
Pennsylvania[2]	67	63	4	4	11,348	7,384	7,429	4,648	2,096
Rhode Island[2]	5	5	.....	.....	778	388	380	289	141
South Carolina	46	41	5	5	1,452	632	714	299	228
South Dakota[2]	68	10	8	8	658	398	352	241	155
Tennessee	96	67	29	29	3,328	1,743	1,890	693	327
Texas	248	179	69	69	6,205	3,606	3,501	1,736	735
Utah	29	5	24	24	496	296	335	206	128
Vermont	14	12	2	2	594	379	402	184	90
Virginia[4]	100	65	35	35	2,545	1,898	1,951	652	463
Washington	39	19	20	20	1,797	987	1,113	593	384
West Virginia	55	41	14	14	1,717	1,235	1,314	541	378
Wisconsin	71	70	1	1	2,750	1,949	1,921	1,168	637
Wyoming	22	10	12	12	267	130	160	81	74

ORGANIZATION OF CONSTITUENT ASSOCIATIONS—Continued.

Constituent Association of	No. Counties in State	No. Component Societies in State Assn.	Number Counties in State Not Organized		No. Physicians in State (7th Ed. Directory)	Number Members of State Association		No. A. M. A. Fellows in State	No. Subscribers to Journal in State*
			1921	1922		1921	1922		
Misc., Foreign, Govt. sub. for Army, Navy & U. S. P. H. S.	.....	.....	.....	.....	.....	.....	.....	131	2,860
Alaska	.....	.....	.....	.....	.....	.....	20	13	10
Hawaii	5	.....	.....	.....	.....	81	92	44	45
Porto Rico	7	.....	.....	.....	.....	116	127	32	33
Philippine Isl.	.....	.....	.....	.....	.....	158	196	64	82
Canal Zone	.....	.....	.....	.....	.....	74	91	25	29
Totals	3,048	2,398	588	588	145,608	85,283	89,048	49,590	28,713
Commissioned Officers[5] and Honorary Fellows								3,432	
								53,022	

* Not including Fellows of American Medical Association.

Note.—The number of members of the different associations stated in this table is in accord with the membership of the several associations as they were reported to the Secretary on April 1, 1922.

The lack of an effective uniform system for reporting the membership of the state associations accounts for whatever discrepancies this table shows and detracts from the value of the statement.

Component societies are those societies which compose the state association. A component society may include one county or more.

1. The state of Maryland has 23 counties and the city of Baltimore; Missouri has 114 counties and the city of St. Louis.

2. These state associations are divided into district societies, and these are listed in the table as component societies. Some of these districts are smaller and some larger than the county, the county lines being ignored.

3. Provision is made for the physicians in each of these counties to join the component society in an adjoining county.

4. Virginia has recently adopted the plan of organization and is now establishing component county medical societies.

5. This figure includes the Medical Corps of the Army, the Navy and the Public Health Service.

HOTEL RESERVATIONS FOR MEMBERS OF THE HOUSE OF DELEGATES

In compliance with the action taken by the House of Delegates last year at the Boston Session arrangements were made to reserve tentatively 150 hotel rooms for the accommodation of members of the House of Delegates at the present session and these rooms were held until after all

reported delegates had been advised by the Secretary's office that they could secure hotel accommodations from the rooms so reserved, and until the secretaries of the state associations holding meetings at which new delegates would be elected during the spring months had been urged to secure reservations for the delegates who were to be elected at their state meetings. This action has been criticized in at least two instances. Consequently, the subject is brought to the attention of the House of Delegates. The criticisms were to the effect that the reservation preempted rooms at one of the leading hotels which it was claimed should have been available to "first come, first served" applicants for reservations addressed to that hotel.

ORGANIZATION

In accordance with the plan of organization recognized by the Association, the several component medical societies are vested with the authority to elect the members of the organization, and the model form of constitution for these component societies, prepared by the Committee on Organization, declares that the society shall judge of the qualification of its members but that as it is the only door to the state medical association and to the American Medical Association for physicians within its jurisdiction, every reputable and legally qualified physician of the county or district who does not support or practice or claim to practice sectarian medicine shall be eligible to membership. The model form for constitution and by-laws of constituent state associations contains the following provision: "Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final."

The intent of these regulations seems to be clear. The authority for carrying out the provision is, however, not stated definitely enough to avoid possible conflict between a component society and the constituent state association. In order to obviate these questions of controversy, the model form for by-laws of component county societies might be modified to read:

"The society shall judge of the qualifications of its members, subject, however, to the provisions set forth in the constitution and by-laws of the state association of which the society is a component branch, but as it is the only door, etc"

The section from the model form for constitution and by-laws for the state association, in order to conform to the provisions of the constitution and by-laws of the American Medical Association, should have added to the section quoted above the phrase

"Provided, however, that on questions of law and procedure, but not of fact, appeal may be made to the Judicial Council of the American Medical Association."

Another subject which merits consideration is the question of the transfer of membership from one component society to another when a member of the organization moves to a new location and then engages in the practice of his profession.

The foregoing instances are cited for the purpose of bringing the general question to the attention of the House of Delegates. It is suggested that the Judicial Council of the American Medical Association be requested to revise the model forms for constitution and by-laws for both component societies and constituent associations. It is further suggested that the Judicial Council be authorized to submit to the constituent state associations such changes as may be unanimously approved by the Council in the fundamental principles set forth in these model forms for constitution and by-laws. It is to be hoped that any revision in these model constitutions and by-laws will commend themselves to the constituent state associations and the component county societies so strongly as to insure their adoption.

AMERICAN MEDICAL ASSOCIATION BULLETIN

The American Medical Association Bulletin was first published as the Councilor's Bulletin. It was planned to devote this publication to the discussion of organization matters. Contributions were received from officers of county and state organizations discussing the value of the county society to its members, the place of the state association in the organization, and similar subjects. These articles from the field did not continue, however, and the Bulletin was devoted to publishing reports of the Councils, conferences held under the auspices of the Councils, and similar matters. In accordance with the action taken by the Board of Trustees at its meeting held last November, an effort is being made to restore the Bulletin to its original purpose and to make it a forum for the discussion of sociologic, economic

and particularly of organization themes. The Board has directed that the Secretary of the Association shall be the Editor of the Bulletin, and advantage is taken here to make special request of the members of the House of Delegates to use the Bulletin for the discussion of topics which should be considered by the House of Delegates. The editorial policy, if it meets with the approval of the House of Delegates, will be to place the columns of the Bulletin at the service of members of the organization, of officers of the component societies and of the constituent associations, and of the members of this House of Delegates and the officers of the Association. It has been suggested that the Bulletin be announced to be the official journal of the House of Delegates and it is requested that action by this body be taken on this proposal.

"MEDICAL ADVISORY COMMITTEE"

Early last January, inquiries were received at the Secretary's office regarding a letter that had been sent by a "Medical Advisory Committee" to the component county medical societies, the constituent state associations and others. This letter which was reprinted in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION and in the American Medical Association Bulletin, suggested the adoption of a preamble and resolutions in accordance with a copy submitted. Twenty-three component county medical societies have transmitted to the Secretary's office reports to the effect that they had adopted the submitted preamble and resolutions offered by the "Medical Advisory Committee" in the form proposed in the circular or with slight modifications. In each instance, the officers of the county medical society reporting such action were asked for the evidence, in support of the postulates incorporated in the preamble, which was submitted to the county society at the time the action was taken; nine replies which were received have been published in the American Medical Association Bulletin. A statement issued by a joint committee of the Board of Trustees and the Judicial Council, discussing these postulates, also was published in THE JOURNAL as well as in the American Medical Association Bulletin. Copies of these Bulletins were mailed to the officers of the American Medical Association, the presidents and secretaries of the constituent associations and of the component societies, and also to the members of the House of Delegates as constituted at the Boston Annual Session; additional copies are available for the information of those members of this House who may not have had access to them.

COOPERATION IN ORGANIZATION

No real good can be accomplished by mere criticism of what has been done or what has not been done in the past. All recognize that much constructive work in the various tasks undertaken by the Association has been accomplished. That these accomplishments have been all that are desired, no one will claim. The fact that there is a conflict of opinion is gratifying because if these conflicting opinions be controlled, they stimulate action that must result in the welfare of the organization, its members and the public service which is rendered. In any organization constituted as is the American Medical Association, development and effective service is conditioned on the helpful cooperation of the component societies and the constituent state associations. Finally, it is to this House of Delegates that the Association looks for the intelligent framing of a constructive policy to be carried out by the officers elected by this House, working in cooperation with the branch organizations.

Additional matters in which the office of the Secretary has been active are reported to the House of Delegates through other channels.

UNFINISHED BUSINESS

At the Boston Session last year, the Reference Committee on Amendments to the Constitution and By-Laws submitted the following to lie over for action at the 1922 session of the House:

"The last sentence of Section 2, Article 5, of the Constitution reads:

> The Trustees shall be ex-officio members of the House of Delegates, but without the right to vote.

We offer and introduce the following amendment—that this sentence be changed to read:

> The Trustees and Ex-Presidents of the Association shall be ex-officio members of the House of Delegates, but without the right to vote.

REPORT OF THE BOARD OF TRUSTEES

To the Members of the House of Delegates of the American Medical Association:

The year 1921 was one of general depression and contraction in the commercial world. Practically all activities were affected, and the printing and publishing field was no exception; the reaction to the abnormal profits of the preceding year or two was such that great losses were common. Our publications, however, were affected but little by the conditions; in fact, the year was a prosperous one from the financial point of view, and satisfactory in respect to all the enterprises connected with the publications and with our business matters generally.

The increase of $1 in the annual dues and in the subscription price of THE JOURNAL went into effect in January, 1921. Naturally, considerable falling off in the circulation was expected on account of this increase in dues. However, there were comparatively few losses on this account; in fact, the mailing list at the end of the year showed an increase of 1,109. The actual count of that list as of Jan. 1, 1922, was 79,669.

Table 1 in the addenda indicates the circulation for the year by weeks; Table 2, the circulation by states and the percentage of physicians in each state receiving THE JOURNAL; Table 3, the number of Fellows and subscribers each year, beginning with 1900. In addition to the circulation indicated in Table 2, 307 copies of THE JOURNAL were taken by the Medical Department of the Army; 250 by the Navy, and 103 by the Public Health Service. Also, there were 2,828 foreign subscribers, including those in United States dependencies.

It will be noticed by Table 3 that there are approximately 50,000 Fellows taking THE JOURNAL, and a little over 30,000 subscribers. The latter number—30,000—exceeds by several thousand the total paid circulation of any other medical weekly. The *British Medical Journal* has the next highest circulation, which, we believe, at the last count was something over 23,000.

ADVERTISING DEPARTMENT

As stated in last year's report, until 1919 the receipts from dues and subscriptions exceeded those from advertising; since 1919, the order has been reversed. For the year 1921

the earnings from advertising exceeded the receipts from dues and subscriptions by $117,367. The total advertising earned during 1921 was $569,078, or an increase over the preceding year of $56,313. The confidence of the medical profession (in the advertising pages), maintained by the high standard governing acceptance of all advertisements, is no doubt a great factor in THE JOURNAL'S volume of, and increasing revenue from, advertising.

COOPERATIVE MEDICAL ADVERTISEMENT BUREAU

The bureau is now on a self-supporting basis; in fact, in December of the last three years it has returned a substantial amount to the various journals, as their proportion over and above the actual expenses of conducting the bureau. It continues to give satisfaction to all its constituent journals, which includes every state journal except that of Illinois; it is of practical assistance to the editors, most of whom are physicians in active practice, the majority having neither the time nor the inclination to look after the details which are assumed by the bureau. The Massachusetts State Medical Society has recently taken over the *Boston Medical and Surgical Journal,* and this has now come into the bureau.

SPANISH EDITION

The Spanish edition is doing fairly well, and the circulation is about holding its own. As with all foreign business, the principal obstacle is the matter of exchange. The present conditions in this regard are a serious handicap in connection with the publication of the Spanish edition; the amounts to be remitted are small and, therefore, proportionately more difficult and expensive to handle than would be the case if the amounts were large. An attempt is being made to overcome in part this handicap. While we are publishing this journal at a loss—the Rockefeller Foundation, as announced in former reports, bearing one half of it—at the same time, it will be remembered that the main purpose is to bring about closer relations between our Latin-American confrères and ourselves. In this it is succeeding. The Spanish journal contains the cream of the scientific matter that appears in the regular edition, and commendatory letters from its readers are received almost daily. Until this journal was started, Central and South America depended almost entirely on Germany—and to a less extent on France

—for their medical periodical literature. The Spanish edition is making known to our Spanish-speaking confrères that the medical profession of the United States is in the vanguard in advancing medical science.

The circulation of the Spanish edition for last year was 3,469, and was widely distributed: Mexico has the largest number of subscribers—648; Cuba has 497; Argentina, 396; Spain, 379; Brazil, 269; Philippine Islands, 241; Chile, 184; Colombia, 109. The rest of the circulation is scattered and includes Ecuador, Guatemala, Nicaragua, Peru, Venezuela, etc. The language in Brazil is Portuguese, which accounts for the comparatively small number circulated in that country.

SPECIAL JOURNALS

There was a slight profit on the publication of three of the special journals—the ARCHIVES OF INTERNAL MEDICINE, the AMERICAN JOURNAL OF DISEASES OF CHILDREN and the ARCHIVES OF SURGERY; and a loss on the publication of the ARCHIVES OF NEUROLOGY AND PSYCHIATRY and on the ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY. The gains on the three practically overcame the losses on the two, there being an actual loss of about $40. All these journals may be regarded as successful and fulfilling the purpose for which they were established. The circulation of each, as of Dec. 31, 1921, is as follows: ARCHIVES OF INTERNAL MEDICINE, 2,611; AMERICAN JOURNAL OF DISEASES OF CHILDREN, 2,692; ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 1,220; ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY, 1,245; ARCHIVES OF SURGERY, 3,146. The ARCHIVES OF NEUROLOGY AND PSYCHIATRY and the ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY appeal to limited specialties; therefore, their circulation is really better than was expected.

QUARTERLY CUMULATIVE MEDICAL INDEX

This index, established to supply up-to-date, ready references to practically all the important medical literature of the world, is proving a success and evidently is thoroughly appreciated. The circulation is slowly increasing: on January 1 of this year there were 1,133 names on the subscription list, which must be considered as eminently satisfactory for a book of this character. It is only just beginning to be known abroad, but already has 108 foreign subscribers.

THE PROPAGANDA DEPARTMENT

It is undoubtedly a fact that the American Medical Association is better known to the general public through the educational service of the Propaganda department than through any other phase of the Association's activities. Few members of the organization appreciate this, as is evidenced by letters received from physicians, in which the question is asked: How are you reaching the public with these articles published in a medical journal? The fact is, all the material published in THE JOURNAL on the nostrum evil and quackery that is of interest to the public is immediately reprinted in leaflet or pamphlet form for general circulation, especially in reply to the queries that are received continually from laymen.

It should again be emphasized that the articles that appear in this department of THE JOURNAL from week to week are but a small part of the Propaganda work. Thousands of letters of inquiry are received and answered yearly and the educational value of this work is not fully appreciated. This work is referred to with increasing frequency in school and college textbooks on general science, civic science, biology, hygiene, etc. These books urge the students to write to the Propaganda department for information and to obtain its books and pamphlets for supplementary reading and study. As an example of what this means in educating the public at its most impressionable age, one instance has been cited: The students of a single class of one metropolitan high school sent in 130 letters of inquiry. Each of these was answered and educational material sent to the students. Almost as important is the work of furnishing information to advertising managers of newspapers and magazines the policy of which is to keep their advertising pages as free as possible from objectionable medical "copy." Hardly a day passes that a request for information is not received from such a source. Here, again, the department is exerting a silent but far-reaching influence to an extent that can be appreciated only by those who are familiar with its daily work.

The second volume of "Nostrums and Quackery" has received a flattering reception by both the medical and the better representatives of the lay press. It is issued in uniform size and style with the first volume, but contains

much more material. There is an increasingly active demand for the books, pamphlets and educational posters, and especially for the stereopticon slides, prepared and issued by the department. The pamphlets and posters already issued are kept up to date and new ones added.

COUNCIL ON PHARMACY AND CHEMISTRY

The Council on Pharmacy and Chemistry, continuing its splendid efforts for rational therapy, has made its influence felt not only in this country but also abroad. Similar bodies, concerned with framing legislation affecting drugs and with service such as that performed by our own Council, have been proposed or established in France, Germany, Belgium and Holland. Through its publication "New and Nonofficial Remedies," which describes the medicinal preparations found worthy of recognition, and its "Annual Reports," which explain the rejection of those found unworthy, the Council provides the means whereby physicians may distinguish between drugs that may be expected to have therapeutic value and those which are more or less worthless. It may interest you to know that the distribution of N. N. R. is world wide; orders have been received from Brazil, Colombia, Cuba, Honduras, Mexico, Nicaragua, Philippine Islands, Porto Rico, Egypt, China, India, Japan, Korea, Manchuria, Alaska, Canada, England, Scotland, Ireland, Switzerland, Syria and the Transvaal. The problems before the Council today are not the complex proprietary mixtures which were the bane of medicine fifteen or twenty years ago, but the "mixed" vaccine, the "pluriglandular" endocrine preparations and the nonspecific protein products of animal and vegetable origin. In addition to many irrational mixtures of this type, the Council is also coping with both the extraordinary claims of firms specializing in intravenous medication and the attempts at commercialization of our new knowledge of vitamins.

The Chemical Laboratory continues to serve the profession by the analyses which it makes for the Council and through the independent investigations which it takes up at the request of the THE JOURNAL or on its own initiative. False claims regarding the composition of medicines sold to physicians are, thanks to our laboratory, less common than formerly. Instead of simple chemical analyses, the laboratory is obliged to make use of the most modern methods in investigating the newer products that are offered.

APPROPRIATIONS FOR RESEARCH

The Board of Trustees has been making appropriations averaging about $3,000 annually for research: $1,500 for the Committee on Therapeutic Research, and a like amount for the Committee on Scientific Research. The former—a subcommittee of the Council on Pharmacy and Chemistry—confines its grants to the encouragement of investigations on matters relating to therapeutics; the latter covers the broader field of scientific medicine. For instance, during 1920 the Committee on Scientific Research granted $450 for continuation of the work on the influence of glands of internal secretion on ovulation; $300 for work on problems of excretion of urea; $400 for the study of bacterial proteins; $300 for work on metabolism of inorganic salts, and $350 to aid in a study of the arachnoid fluid in early syphilis. Most of the expenditures of the Committee on Scientific Research, as well as of that on Therapeutic Research, are for materials; occasionally they are for special assistants. This year, a special appropriation of $1,000 was made for the Council on Pharmacy and Chemistry, to be used in the conduct of an exhaustive investigation of the subject of local anesthetics. It is a continuation of the work that has been conducted during the last two years by a special committee of the Council, of which Dr. Emil Mayer, of New York, was chairman. Three reports made by this committee have appeared—the first in the *Laryngoscope* in July, 1920, an abstract of which was published in THE JOURNAL for July 31 of the same year. The final report appeared in THE JOURNAL, Oct. 22, 1921. The practical results of this investigation—which, however, covered only laryngology, rhinology and otology—warranted the Council in asking for a special appropriation to cover the general field of medicine. A new committee, with Dr. Mayer still as chairman, has been appointed and is now formulating its plans of work.

NEW BUILDING

In its report to you at Atlantic City, in 1919, your Board of Trustees stated that the increased activities of the Association were beginning to crowd the present facilities at headquarters, and that it had under consideration the tearing down of the old building and the extension of the steel and concrete building to the alley. Soon afterward, conditions in the building trades became so unsettled that it was decided to defer the matter of building for a time. However, as matters became more settled, the Board authorized the architects to prepare plans for building in the spring of 1921. These plans

were presented to the Board at its annual meeting in February, 1921. The Board approved the plans and authorized the architects to work up the specifications and to call for bids, with the idea of commencing to build early in the spring of 1921. As the lowest bid was $420,000—over $100,000 higher

Fig. 1, Building "A."—The three-story and basement building originally erected, and occupied in December, 1902.

than the architect's estimate—it was decided to postpone building. This matter was discussed in detail in our report to you last June, to which we refer.

The basement has been the main problem: Here all the large presses have to be located; here also is the logical place for paper storage. But the space would not be sufficient even for our present work if the heating and steam plants and the

coal storage were to continue to occupy basement space, as is now the case. Last year the plan was solved, at least in part, by providing for a subbasement for the heating plant and machinery. This was a rather expensive and an uneconomical solution; the cost for the subbasement was estimated at $25,000. In taking up the matter this year, the architects suggested—as they had done the year before—that, if possible,

Fig. 2 (Building "A").—The old building of the Association as it appeared in 1910. This view shows the added fourth story erected in 1905, together with the remaining houses of the original purchase.

we purchase the property adjoining on the east. Without going into details regarding the difficulties of securing this property—it was owned by two different persons—it was purchased last December, for approximately $32,000—only $7,000 more than the subbasement would have cost. It consists of a lot 40 by 100 feet, on which was a cheap double house. The obtaining of this property made it advisable to

reconsider the original plans. After giving the subject careful consideration, keeping in mind not only the present but also the possible future needs of the Association, the Board decided to carry out the plans outlined in its report of 1919 and, in addition, to include the new property in the complete structure. This will provide a building 100 by 160 feet, six stories and a high basement, of steel and concrete construction, fireproof, and sufficiently strong to carry at least two

Fig. 3 (Buildings "A" and "B").—The Home of the Association.

more stories if more room should become necessary. Not only will there be sufficient room in the basement for the heating plant and the machinery appertaining to it, but also increased floor space. There will be an assembly room, 40 by 60, without pillars, that will seat from 300 to 350 persons, and a smaller room to seat from sixty to seventy-five; committee rooms also are provided for, besides the various departments, offices and storerooms. A slight change will be made in the

main entrance on Dearborn street, and there will be an employees' entrance to the printing department on Grand Avenue; also another passenger elevator will be installed at the side of the present one.

This building will provide more room than is just now required; the mistakes of the past, however, have been in overconservatism. For instance: The first building [Building

Fig. 4.—Showing new property.

"A," Fig. 1] had hardly been occupied when it was outgrown. In about two years, additional property was bought, the building extended back 40 feet, and another story added [Building "A," Fig. 2]. In two years, still more room was needed, and one of the houses adjoining the old building on the south was taken over, altered and utilized [adjoining building "A" in Fig. 2]. Then, early in 1910, we moved into Building "B" [Fig. 3], which had just been completed, and rented the old

building. In 1920, when it was found inadvisable to build, the old building [Building "A"] was taken over and occupied.

The new building should be ample for many years, and yet if the proposed popular medical magazine is published and is the success that most of us expect it to be, and especially if the Association's activities continue to expand, even the additional stories now provided for may be needed. The big—the important—thing is that we shall have space for a printing plant such as we have needed for several years. It may be recalled that, owing to lack of facilities, we were compelled to discontinue printing the Pennsylvania, Missouri and Indiana state journals, and that we were not able to undertake the publication of two special journals that were asked for. We have also been handicapped, on account of lack of space, in carrying on the regular work. The importance and the practical value of such a printing and publishing plant as the Association now owns should be emphasized. It gives the Association advantages in many ways: The large amount of paper used, especially in printing THE JOURNAL, makes it possible to deal directly with the mills and to obtain prices below those which the average printer has to pay; up-to-date labor-saving machinery, especially that adapted specifically to medical magazine printing, makes for economy of production. The ample space in the new building will make it possible for our mechanical department to do still more for the advancement of medicine in the United States—one of the fundamental objects for which the Association was organized—because it can print and circulate at a comparatively low figure scientific magazines that otherwise would be very expensive. Finally, the completion of this building will mean the accomplishment of an ambition which the officers and Fellows of the Association have had for many years—a substantial, well-equipped home that will be a credit to the medical profession of the United States and particularly to the American Medical Association. As this matter is put into type, we cannot state the cost, as the bids are not yet submitted. However, the building fund accumulated by order of the House of Delegates will, we are sure, be sufficient to complete the construction of the new building.

REFERENDUM ON THE THERAPEUTIC USE OF ALCOHOL

The results of the referendum conducted by THE JOURNAL during December and January were published in detail in THE JOURNAL, and it is unnecessary to recapitulate. The Board desires, however, to call attention to the special importance

of the comments made by physicians in returning the questionnaire. These comments were of even greater value than the statistical matter; they reflected the extreme dissatisfaction of the profession with the conditions which have resulted from the regulations for the prescribing of alcoholic preparations. Analysis of the comments showed that, aside from the fact that they are taxed to enforce a law which is primarily for the good of the public, physicians are satisfied with the control of narcotics, as regulated under the Harrison Narcotic Law; a large number suggested that the government take over the whisky, including its storage and sale. It has been proposed that the government supply it in sealed packages—say, 8, 16 and 32 ounces—for medicinal use only, at a fixed price, under regulations similar to those of the Harrison Narcotic Law. Such a plan would make available to physicians a drug of dependable quality—the fact that such whisky was not obtainable was repeatedly emphasized in the comments—and lead to the elimination of unsatisfactory conditions resulting from limitations in quantities of the drug and in the number of prescriptions, such as now exist. It is believed that if this matter is presented to the Internal Revenue Department and to Congress, with the support of the medical profession, some such plan as is outlined may be adopted. The referendum demonstrates that a majority of those members of the medical profession who replied to the referendum believe whisky to be a necessary therapeutic agent. It also showed that the conditions are such as to demand a change in the regulations now existing permitting the use of alcohol. In any event, the Board of Trustees believes that conditions demand action on the part of the Association and recommends that the suggested appeal to the federal government be endorsed by the House of Delegates, and that it be referred to a special committee, to one of the councils or to the Board of Trustees for further action.

REDUCTION IN ANNUAL DUES

As will be remembered, in 1920 conditions in the printing trade reached a point at which THE JOURNAL was being published at a steadily increasing loss, specifically because of the high cost of paper and of labor, and in November, of that year, a special meeting of the House of Delegates was called to authorize increasing the annual dues from $5 to $6. Soon afterward, however, prices began to go down until now the price of paper is practically two-thirds of what it was in the fall of 1920; the cost of labor also has been decreased to a

slight extent. The Board therefore believes that by the end of the year conditions will be such that we can revert to the $5 dues. It recommends, however, that the by-law governing the matter be amended so as to leave the regulation of the dues to the Board of Trustees; if an emergency in the future should necessitate it, the annual dues and the subscription might then be changed without calling together the House of Delegates. The present by-law (Chapter XVII) reads:

ANNUAL FELLOWSHIP DUES: The annual Fellowship dues shall be six dollars, payable in advance on the first day of January of each year, of which not less than five dollars shall be credited to the subscription for one year to THE JOURNAL.

The Board suggests that the following be added:

Provided, however, that the Board of Trustees, by unanimous vote, may change the amount of the annual dues; and provided further that these dues shall not be less than $5.00 or more than $6.00 per annum, and that any such change shall be announced in THE JOURNAL of the American Medical Association on or before November 1 of the year preceding that in which the change is to become effective.

THE BOARD OF TRUSTEES—THE BOARD OF DIRECTORS

Until two years ago, the duties of the Board of Trustees were defined in the Constitution (Article 7) as follows:

"The Board of Trustees shall have charge of the property and financial affairs of the Association."

In other words, the functions of the Board of Trustees pertained solely to the publication of THE JOURNAL and to the control of the business and financial affairs of the Association. At the New Orleans session, in 1920, the House of Delegates amended the Constitution by the addition of the following clause:

"and shall perform such duties as are prescribed by law governing directors of corporations."

The Board of Trustees understands the modification to mean that the Board now bears to the House of Delegates the same relation that a board of director bears to the stockholders of a corporation; in other words, in the interval between the annual sessions, it is to act for the House of Delegates and to have a general supervision of all the activities of the Association.

That the Board of Trustees might keep in closer touch with all the work at headquarters, it created an Executive Committee, to meet monthly, or as often as necessary, at the Association headquarters. This committee consists of the local

member of the Board and two others, with the chairman of the Board and the general manager as ex-officio members. Occasionally, the President or the President-Elect, or both, have been in attendance at the Executive Committee meetings.

Since the adoption of the modification of the Constitution, the Board of Trustees and its Executive Committee have been considering certain problems that do not come directly under any of the constituent councils. It is at this time, however, prepared to report only on the following:

PAY CLINICS, DIAGNOSTIC CLINICS AND GROUP PRACTICE

At the meeting of the Board of Trustees on November 10-12, as stated in THE JOURNAL for November 26, p. 1741, the question of pay clinics, diagnostic clinics and group practice was given extended discussion. Inasmuch as such organizations exist and are rapidly increasing, it is evident the American Medical Association should recognize this fact and give the matter consideration. The Executive Committee was authorized to consider the subject in detail and to report what action, if any, should be taken. The committee later recommended that a small committee be appointed to make a survey of the whole subject of group practice, pay clinics and similar combinations. The recommendation of the committee was approved by the Board of Trustees. As an initial movement in this direction, the committee asked Dr. H. R. M. Landis of Philadelphia to make a preliminary survey of the Cornell Pay Clinic. March 20, Dr. Landis made a report based on three visits to the clinic. He confirms the statements of the dean of Cornell, as published in THE JOURNAL, November 26, p. 1755, and indicates that the clinic was then conducted under the regulations outlined by Dean Niles. Quoting from Dr. Landis' report:

"No patient can be seen outside of the dispensary by any member of the staff; nor can any patient who needs surgical treatment be operated on by any one connected with the Cornell Medical School. Unattached patients who seek advice and who are found to be ineligible are given the names of those physicians not connected with the dispensary, and told that they can consult any one of these physicians, but that they must make their own choice. If, on the other hand, they have a physician, they are urged to return to him. . . . The family budgets of all applicants are carefully graded in order to exclude any one who can afford the services of a private physician. Several instances occurred at the time of my visits in which service was denied because of the income. . . . Again several instances were brought to my attention in which a patient referred by a physician was found to have an income in excess of that which would make him eligible;

such cases were promptly returned to their physicians. . . . At the present time the great majority of the people coming to the Clinic is composed of those who have had some long-standing ailment. . . . It is questionable whether the private physician was much injured by the loss of these patients. . . . The one distinct impression I obtained was that the physician who does honest work has nothing to fear from such a clinic; on the contrary, it will furnish him excellent consultant facilities for those of his patients who can afford a small fee only. . . . In my opinion the public as a whole prefers going to a private physician rather than to a public clinic. . . .

"As a result of my observations, I would say that there are three outstanding facts for consideration: 1. What shall be the attitude of the Association toward the sociological aspects of this experiment? This, it seems to me, is the outstanding feature. It may be that ultimately the present plan will need revision, but the question of principle will remain the same. 2. What answer is to be made to the profession if the experiment is successful? Most of the criticisms I have seen were made apparently on the assumption that such a plan was a menace to the doctor. The rights of the public seem to have escaped their attention. Careful consideration will show that the doctor doing good work has nothing to fear. On the other hand, there is no gainsaying the fact that the shiftless practitioner will most certainly be injured. 3. Can such clinics, granting that the experiment is successful, be recognized safely outside of the jurisdiction of accredited hospitals? Conducted by a group of individuals solely for gain, they might be misused."

The summary of Dr. Landis' report records an individual investigation of the subject of one pay clinic; and as these forms of practice have developed rapidly and concern the private practitioner and his professional and economic status for good or evil, according to the relationship which exists between him and them, the Board believes that the Association should attempt to establish the fundamental principles and policies for the conduct of these forms of practice, if they are to continue. Therefore, the Board recommends that a survey be made of the existing pay clinics, diagnostic clinics and group practice, so that there may be a basis on which to outline such principles and policies as would assure greatest good to the public and to the general practitioner. As this matter includes both ethical questions and matter pertaining to hospitals, clinics, etc., the Board recommends that this work should be conducted jointly by the Judicial Council and the Council on Medical Education and Hospitals.

The latter is making a survey of dispensaries, outpatient departments and group clinics, a report of which will appear in the Hospital Number of THE JOURNAL. It experienced some difficulty in securing a complete list of groups, apparently because of the confusion as to what constitutes "group practice"; also, some groups, it appears, do not have, or hesitate to furnish, the information asked for. However, thus far the Council has learned of 139 group clinics. Definite information is being obtained from each, including the number of patients treated annually, classes of people treated and, especially, the names of those who make up the groups. In addition, each group is asked for a general statement in regard to the diagnostic service rendered to other physicians in the community. So far as reports have been received, it appears that this service for other physicians is quite generally provided.

AMERICAN RED CROSS

At our annual meeting in November, 1921, the secretary of the Board reported the result of a conference with the vice chairman of the Central Committee of the American Red Cross, in regard to the present and proposed future activities of that organization in public health work. He also presented a copy of a letter written by him to the vice chairman of the Central Committee of the American Red Cross, in which the opinion was expressed that the time had arrived when the American Red Cross should cease its public health activities and should restrict its work to the relief of disabled ex-service men in the hospitals and in their homes, in addition to the purposes for which it was originally organized, as designated in its charter. The Board approved the action of the secretary and endorsed the opinions expressed by him in the letter referred to. Apparently, the Central Committee of the American Red Cross has not modified its public health program. It is the opinion of the Board that the Association, through the House of Delegates, should take appropriate action to convince those in authority that the public health activities of the American Red Cross are no longer necessary and if continued are likely to promote community irresponsibility and helplessness in regard to its own welfare.

BULLETIN

As one of the means of securing more practical and intimate cooperation between the officers of the component societies and of the constituent associations and the officers of

the American Medical Association, the Board of Trustees has directed that the AMERICAN MEDICAL ASSOCIATION BULLETIN —originally started as a Councilor's Bulletin but in more recent years utilized to distribute full reports of the Council activities, conferences and similar matters—shall be issued under the editorship of the Secretary and the Field Secretary of the Association. The purpose is to devote the BULLETIN to a full and free interchange of opinion on organization subjects and related topics, including economic, social and ethical questions pertaining to the practice of medicine. Not the least of its functions, however, will be to develop better and more effective organization.

LAY-MEDICAL MAGAZINE

The Board of Trustees and its Executive Committee have discussed the subject of the proposed lay-medical magazine on several occasions, but the Board is not prepared at this time to make a report. However, a conference has been arranged for May 19 and 20, in St. Louis, between the Council on Health and Public Instruction and the Board of Trustees, for the purpose of discussing the subject in full.

GORGAS MEMORIAL

Mr. H. de Joannis of Panama appeared before the Board of Trustees at its November meeting, and presented an outline of the proposition for a memorial to be erected to Major-General Gorgas at Panama. Mr. Joannis' mission before the Board was to secure the cooperation of the American Medical Association with the officers and directors of the Gorgas Memorial Institute of Tropical and Preventive Medicine at Panama. After discussion, the Board unanimously approved of the proposition, gave assurance that the American Medical Association would cooperate in the work, and instructed the Secretary of the Board to notify Dr. Braisted, the chairman of the Gorgas Commission, that the American Medical Association was willing to cooperate. The matter came before the Executive Committee at its meeting in December, through a letter received from Dr. Braisted suggesting that a committee be appointed to represent the Association. The Executive Committee recommended to the Board that such a committee be appointed and, the Board approving, the matter

was referred to President Work, who appointed Dr. George E. de Schweinitz of Philadelphia, Dr. Charles W. Richardson of Washington, D. C., and Dr. Fred B. Lund of Boston as a committee to represent the American Medical Association and to act in an advisory capacity to the Board of Trustees.

INTERNATIONAL CONGRESS OF HYGIENE AT STRASBOURG

A request was made by Dr. Haven Emerson, through the President-Elect, Dr. de Schweinitz, for the cooperation of the American Medical Association in promoting the work of the International Congress of Hygiene at Strasbourg in the spring of 1923. The matter is referred to the House of Delegates, with the suggestion that this international congress be endorsed by the House, and that volunteers be encouraged to attend the congress.

LEGAL DEFENSE INDEMNITY IN MALPRACTICE SUITS

The Board of Trustees has had under consideration the need of cooperation between the committees on medical defense in the various states through what might be called the Legal Defense Department of the Association, under the jurisdiction of a legislative bureau. The Board is not yet ready to make a definite, final report as to just how this work shall be undertaken, but heartily commends the idea and asks the endorsement of the House of Delegates, to put the proposition into effect in a reasonable time.

FIELD SECRETARY

The Board for a long time has felt that there should be closer personal touch between the component county and constituent state associations and the central body than has prevailed heretofore. The many details connected with the secretary's functions at headquarters have made it impossible for him to do full justice to this phase of organization work. Therefore, the Board, acting under its new authority, looked for some one to take up this field work. Last November, after careful consideration on the part of the Board, the position was offered to, and accepted by, Dr. Olin West, of Nashville, Tenn. Dr. West for twelve years has been executive secretary of the Tennessee State Board of Health

and for ten years secretary of the Tennessee State Medical Association. He is a man who, we believe, is thoroughly competent to fill the position. He reported for duty on April 15, and we bespeak for him the cooperation of the officers and members of the organization.

Respectfully submitted.

A. R. MITCHELL,
D. CHESTER BROWN,
OSCAR DOWLING,
CHARLES W. RICHARDSON,
W. T. SARLES,
WALTER T. WILLIAMSON,
FRANK BILLINGS,
WENDELL C. PHILLIPS,
THOMAS MCDAVITT.

ADDENDA TO TRUSTEES' REPORT

SUBSCRIPTION DEPARTMENT

TABLE 1.—The following table indicates the number of copies printed each week, the total number for the year and the weekly average:

January 1	80,981		July 2	80,240	
January 8	80,555		July 9	80,365	
January 15	80,442		July 16	80,626	
January 22	81,553		July 23	80,454	
January 29	80,775		July 30	80,983	
		404,306			402,668
February 5	80,900		August 6	80,082	
February 12	80,546		August 13	80,708	
February 19	81,191		August 20	80,268	
February 26	81,278		August 27	80,379	
		323,915			321,437
March 5	80,934		September 3	80,099	
March 12	80,907		September 10	80,508	
March 19	80,477		September 17	80,216	
March 26	80,515		September 24	80,121	
		322,833			320,944
April 2	80,516		October 1	80,425	
April 9	80,156		October 8	80,515	
April 16	80,498		October 15	80,628	
April 23	80,736		October 22	85,569	
April 30	80,471		October 29	85,790	
		402,377			412,927
May 7	80,406		November 5	85,400	
May 14	80,573		November 12	85,253	
May 21	88,963		November 19	85,468	
May 28	80,491		November 26	85,347	
		330,433			341,468
June 4	80,417		December 3	85,358	
June 11	80,472		December 10	80,481	
June 18	80,394		December 17	80,813	
June 25	80,442		December 24	80,532	
		321,725	December 31	80,644	
					407,828
Total					4,312,861
Weekly average					81,374

PERCENTAGE OF PHYSICIANS RECEIVING THE JOURNAL

TABLE 2.—The number of physicians in the United States (based on the Seventh Edition of the American Medical Directory), the number receiving THE JOURNAL, and the approximate percentage in each state are indicated below. The copies to the U. S. Army, U. S. Navy, U. S. Public Health Service, etc., are not included:

State	Physicians in State 7th A. M. Directory	Number Receiving JOURNAL	Approximate Percentage 7th A. M. Directory
Alabama	2,405	798	33
Arizona	380	246	65
Arkansas	2,450	640	26
California	6,766	4,138	61
Colorado	1,817	1,004	55
Connecticut	1,729	1,109	64
Delaware	262	159	60
District of Columbia	1,689	640	38
Florida	1,281	587	46
Georgia	3,406	1,033	30
Idaho	353	258	47
Illinois	10,651	6,842	64
Indiana	4,446	1,989	45
Iowa	3,536	1,972	56
Kansas	2,550	1,273	50
Kentucky	3,323	1,047	31
Louisiana	2,001	1,045	52
Maine	1,105	513	46
Maryland	2,364	1,448	61
Massachusetts	5,959	3,842	64
Michigan	4,593	2,510	55
Minnesota	2,628	1,851	70
Mississippi	1,761	558	32
Missouri	5,921	2,574	43
Montana	620	340	55
Nebraska	1,965	1,114	57
Nevada	147	88	60
New Hampshire	641	370	57
New Jersey	3,260	2,180	67
New Mexico	529	243	46
New York	16,284	9,026	55
North Carolina	2,236	995	44
North Dakota	556	372	67
Ohio	8,092	3,932	49
Oklahoma	2,622	982	37
Oregon	1,145	582	51
Pennsylvania	11,348	6,782	60
Rhode Island	778	444	57
South Carolina	1,452	561	39
South Dakota	658	385	59
Tennessee	3,328	1,060	32
Texas	6,205	2,471	40
Utah	496	319	64
Vermont	594	278	47
Virginia	2,545	1,118	44
Washington	1,797	996	55
West Virginia	1,717	931	54
Wisconsin	2,750	1,814	66
Wyoming	267	165	62

The number of Fellows and of subscribers (not including advertisers, exchanges, libraries, colleges, etc.) on THE JOURNAL mailing list each year, beginning with 1900, are here given:

Year	Fellows	Subscribers
January 1, 1900	8,445	4,633
January 1, 1901	9,841	8,339
January 1, 1902	11,107	10,795
January 1, 1903	12,553	12,378
January 1, 1904	13,899	14,674
January 1, 1905	17,570	15,698
January 1, 1906	20,826	17,669
January 1, 1907	26,255	20,166
January 1, 1908	29,382	20,880
January 1, 1909	31,999	18,983
January 1, 1910	33,032	19,832
January 1, 1911	33,540	20,504
January 1, 1912	33,250	21,620
January 1, 1913	36,082	19,863
January 1, 1914	39,518	19,751
January 1, 1915	41,254	20,430
January 1, 1916	41,938	22,921
January 1, 1917	42,744	22,156
January 1, 1918	43,420	23,117
January 1, 1919	42,366	24,687
January 1, 1920	44,340	30,032
January 1, 1921	46,669	31,347
January 1, 1922	48,937	30,175

TREASURER'S REPORT

Report of the Treasurer of the American Medical Association for the year ending December 31, 1921

ASSOCIATION RESERVE FUND

Reserve Fund as at December 31, 1920		$295,554.41
Interest—Bonds	$12,745.00	
Interest—Uninvested balance	373.19	
		$ 13,118.19
Reserve Fund as at December 31, 1921		$308,672.60

TREASURER'S GENERAL ACCOUNT

Balance as at December 31, 1921	$ 265.34

DAVIS MEMORIAL FUND

Bonds as at December 31, 1920		$ 3,708.25
Bank Balance December 31, 1920	$ 138.79	
1921 Interest on Bonds	170.00	
1921 Interest on Bank Balance	6.11	
		$ 314.90
Total Fund as at December 31, 1921		$ 4,023.15

AUDITOR'S REPORT

CHICAGO, January 30, 1922.

To the Board of Trustees,
American Medical Association, Chicago, Illinois.
Dear Sirs:

In accordance with your instructions, we have audited the accounts of the American Medical Association for the year ended December 31, 1921, and have prepared therefrom the following statements which are appended hereto.

Balance Sheet as at December 31, 1921..... Exhibit "A"
Income Account for the year ended December 31, 1921..... Exhibit "B"
Journal Operating Expenses—Year 1921....Schedule "1"
Association and Miscellaneous Expenses—Year 1921 .....Schedule "2"

The Balance Sheet submitted properly presents, in our opinion, the financial position of the Association as at December 31, 1921, and the Income Account, the results of the operations of the Association for the year then ended; subject to the remark that no provision has been made for accrued interest, taxes and "Journal" subscriptions paid in advance, and that no valuation has been placed on subscriptions and memberships due and unpaid.

We verified the cash in bank by certificates received from the several depositories and that on hand by actual count. We also inspected the securities for the investments of the Association Reserve Fund and found them in order; these securities are stated at cost, without regard to the market value prevailing at December 31, 1921.

The Surplus Fund of the Association has increased since December 31, 1920, $132,658.73, representing the net income for the year 1921. This increase is spread over the assets and liabilities as follows:

Increase in Fixed Assets		$ 4,222.05
Increase in Current and Working Assets		200,878.09
		$205,100.14
Less:		
Decrease in Prepaid Expenses	$53,072.66	
Increase in Accounts Payable	14,891.03	
Increase in Advance Payments	4,477.72	
		$ 72,441.41
Net Increase		$132,658.73

During the course of the audit we made an exhaustive test of the various sources of income and verified the expenditures against properly approved vouchers on file. We are

pleased to report that the accounts are well and accurately maintained.

Yours truly,

MARWICK, MITCHELL & Co.

EXHIBIT "A"

BALANCE SHEET AS AT DECEMBER 31, 1921

ASSETS:		
Property and Equipment at Cost, less Depreciation:		
Real Estate and Buildings		$195,337.88
Machinery		52,402.49
Type and Metal		6,862.13
Furniture and Equipment		17,035.84
Chemical Laboratory		2,142.57
Library		662.53
Total Property and Equipment		$274,443.44
Reserve Fund Investment:		
Government and Railroad Bonds—at Cost	$287,624.05	
Funds in Bank Awaiting Investment	21,048.55	
		$308,672.60
Current Assets:		
Cash in Bank and on Hand	$ 36,361.51	
U. S. Government Securities	200,000.00	
Notes Receivable	1,546.72	
Accounts Receivable:		
Advertising	$61,402.74	
Cooperative Medical Advertising Bureau	6,946.47	
Reprints	4,110.93	
Miscellaneous	10,371.52	
	$ 82,831.66	
Inventory of Materials, Supplies and Work in Progress	$ 74,995.97	
		$395,735.86
Prepaid Expenses:		
Insurance Premium	$ 2,132.99	
Session—1922 Expenses	726.45	
		$ 2,859.44
Total		$981,711.34
LIABILITIES:		
Accounts Payable:		
Cooperative Medical Advertising Bureau		$ 5,077.52
Miscellaneous		30,568.31
		$ 35,645.83
Advance Payments on Publications		15,039.21
Association Reserve Fund (invested as noted above):		
Amount thereof as at December 31, 1920	$295,554.41	
Interest received on Bonds owned and uninvested cash—Year 1921	13,118.19	
		$308,672.60
Surplus Fund:		
Amount thereof as at December 31, 1920	$489,694.97	
Net Income for the Year ended Dec. 31, 1921	132,658.73	
		$622,353.70
Total		$981,711.34

EXHIBIT "B"

INCOME ACCOUNT

FOR THE YEAR ENDED DECEMBER 31, 1921

JOURNAL:		
Gross Earnings:		
Fellowship Dues and Subscriptions		$ 451,711.85
Advertising		569,078.88
Jobbing		17,663.81
Reprints		6,287.84
Books		9,999.23
Insignia		4,394.98
Miscellaneous Sales		9,085.53
Interest		8,540.49
Gross Earnings from JOURNAL		$1,076,762.61
Operating Expenses, Schedule "1"		826,576.25
Net Earnings from JOURNAL		$ 250,186.36
Miscellaneous Income:		
Rents	$ 3,000.00	
Special Journals	6,768.94	
Cooperative Medical Advertising Bureau	672.56	
Miscellaneous	15,436.97	
		$ 25,878.47
Net Earnings from JOURNAL and Mis. Income		$ 276,064.83
Association Expenses, Schedule "2"	$92,238.51	
Less—Session 1921	2,237.50	
	$90,001.01	
Miscellaneous Expenses, Schedule "2"	53,405.09	
		$ 143,406.10
Net Income		$ 132,658.73

SCHEDULE "1"

JOURNAL OPERATING EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1921

Wages and Salaries	$325,157.96
Editorial, News and Reporting	10,812.83
Paper—JOURNAL Stock	292,973.73
Paper — Miscellaneous	16,939.97
Electrotype	15,638.67
Binding	437.94
Ink	8,138.56
Postage—First Class	21,757.66
Postage—Second Class	38,673.22
JOURNAL Commissions	8,039.90
Collection Commissions	1,157.06
Discounts	20,092.38
Express and Cartage	3,892.42
Exchange	3,814.37
Office Supplies	1,552.06
Telephone and Telegraph	1,634.92
Office Jobbing	7,066.32
Power and Light	4,384.88
Fuel	4,856.32
Factory Supplies	11,086.49
Repairs and Renewals—Machinery	4,180.14
Bad Debts—Net	1,763.53
Miscellaneous Operating Expenses	13,598.60
	$817,649.93

Depreciation of Property and Equipment:			
Machinery	10%	$5,822.50	
Furniture and Equipment	10%	1,513.84	
Factory Equipment	10%	479.03	
Type	15%	508.50	
Metal	15%	702.45	
			$ 8,926.32
Total			$826.576.25

SCHEDULE "2"

ASSOCIATION AND MISCELLANEOUS EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1921

Association Expenses:	
Association	$ 32,487.22
Health and Public Instruction	12,828.67
Pharmacy and Chemistry and Chemical Laboratory	21,864.91
Medical Education and Hospitals	20,825.78
Organization	3,373.03
Therapeutic Research	620.84
Laboratory Depreciation—10%	238.06
Total Association Expenses	$ 92,238.51
Miscellaneous Expenses:	
Insurance and Taxes	$ 8,814.03
Legal and Investigation	678.00
Sundry Publications	18,738.03
Building "B" Depreciation—5%	7,196.52
Building "B" Expense	2,605.94
Library Depreciation—10%	73.62
Miscellaneous	15,298.95
Total Miscellaneous Expenses	$ 53,405.09

Report of the Judicial Council

To the Members of the House of Delegates of the American Medical Association:

During the past year, the Judicial Council has received a number of communications asking for opinions on subjects dealing largely with questions of ethics. In the majority of instances, it has felt obliged to refrain from giving opinions for the reason that the subject matter presented did not properly come within the jurisdiction of the Council as now defined in the By-Laws of the Association. The fact that so many communications of the character mentioned have been received is an indication that the idea is rather prevalent that it is a function or a duty of the Judicial Council to act in such matters. It also indicates the need of some tribunal to which members or Fellows and local or state organizations may appeal for opinions on matters of an ethical nature which may affect members of the profession, individually or collectively, or which may involve their relations to the public.

Logically, it would seem that all such matters should be referred to the Judicial Council and that authority should be given the Council in the By-Laws to act. Should the House of Delegates concur in this view, we recommend that the By-Laws be amended so as to extend the jurisdiction of the Judicial Council to include all such matters. It is perfectly obvious that the Judicial Council should have original jurisdiction in all matters relating to the Scientific Assembly and to Fellowship therein. We recommend, therefore, that Section 1, Article IX, of the By-Laws be amended to read:

> This power shall extend to and include (1) all questions involving Fellowship in the Scientific Assembly or the obligations, rights and privileges of Fellowship; . .

the section to continue as at present except for necessary renumbering.

We also offer the following amendment to be inserted immediately preceding the final paragraph of Section 1, Article IX:

> The Judicial Council shall have jurisdiction in all questions of ethics and in the interpretation of the laws of the organization.

Many of the questions submitted to the Council involve the subject of advertising. As is well known, there is a marked

tendency of late for physicians to organize themselves into so-called groups under various designations or titles, such as group clinics, diagnostic clinics, group medicine, medical institutes, the (blank) medical academy, and similar names. Unfortunately some of these groups are advertising in a manner that would be considered most reprehensible if done by an individual physician. The Council has given much thought to this subject. It is unable to see any difference in principle between a group of physicians advertising themselves under whatsoever title they may assume and an individual physician advertising himself. As a result of their deliberations on the subject, the Council adopted the following resolution, which if approved by the House of Delegates is offered as an amendment to Section 4, Article I, Chapter II, of the Principles of Medical Ethics:

Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and specially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not *per se* improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

There is now pending before this House of Delegates a proposed amendment to Section 2, Article V, of the Constitution to make the ex-Presidents of the Association *ex-officio* members of the House of Delegates. We recommend that the amendment read as follows:

The Trustees, the ex-Presidents of the Association and the members of the several Councils shall be *ex-officio* members of the House of Delegates without the right to vote, provided that members of the Councils who are also elected delegates may exercise all of the rights of elected delegates."

ADVERTISING MEDICAL INSTITUTIONS

There was submitted to the Council an inquiry as to whether a given advertisement of a certain medical institution, which the said institution desired to run in the public press, was ethical or unethical, and if not ethical, wherein specifically it was unethical. The answer to this question cannot be based solely on the wording of the advertisement, but the advertisement must be considered in connection with the institution presenting it. It is perfectly evidence that an advertisement which would be proper under one set of conditions might be highly improper under a different set. The institution in question was organized a short time ago by a group of public spirited citizens as a stock company for profit, the purpose of the organization being to treat patients suffering with venereal diseases. The advertisements carried in the lay press by the institution were for a time, to say the least, flagrant violations of medical ethics. After several interviews with the incorporators of the institution by representative members of the medical profession, the form of the organization was changed from that of an organization for profit to that of an organization not for profit, and a desire is now expressed by the directors of the organization to have its lay advertisements conform to medical ethics.

The first question to be answered is: Is the institution itself ethical? Ethics relate to conduct. There is no difference in principle between medical ethics and ethics in general. Conduct has to do not simply with the outward or visible acts of a person, but it has a more comprehensive meaning and relates to the general line of a person's—or in this case a corporation's—moral proceedings. The proceedings, then, of this institution must be analyzed as to its effects on the people it treats, the medical profession, and the community in general. The organizers of the institution undoubtedly were of the opinion that there was a great need for just such an organization, based on the belief that there are a great many individuals suffering with venereal diseases; that these cases are not properly treated by physicians; and that there is no provision made by the profession for the treatment of those suffering with these diseases who are unable to pay the usual fees for such services. The need of such an institution is denied, on the grounds that the medical profession is perfectly competent to treat and is so treating this class of cases, and furthermore, ample provision has

long been in existence for the free treatment of those persons who are unable to pay or for very nominal fees from those who may be able to pay something. Hence the need for this institution did not exist.

It was decided long ago that the practice of law by a corporation was against public policy and the same has been prohibited by law in many states. The relations between patient and physician are more intimate than are those between client and attorney. It is impossible for that intimacy of relationship to exist between an individual and a corporation, and if it is against public policy for a corporation to practice law, how much more so must it be for a corporation to practice medicine?

Many persons imbued with an altruistic spirit are often led to do things which a more careful analysis would have convinced them was not really altruistic, for that which is altruistic must be for the common good, and therefore could not be against public policy. But how can a corporation organized for the purpose of treating disease and relieving human suffering be against public policy? Certainly not in its intentions nor in the good which it might do to a few. It must be, therefore, in the fact that the harm which it does to the community as a whole outweighs the good which it may do to a few. When an individual (or a corporation) starts out to do good he should consider carefully whether the immediate good done is not more than outweighed by ultimate harm to those supposed to be benefited as well as harm to those composing another group in society, or to society as a whole. In the present case, the institution does harm to the individual, to the medical profession, and to the community. No direct harm can be said to be done to the individual by treating him for his venereal disease free or for a very nominal sum if he is honestly unable to pay for his services, but when this same treatment is given to individuals who are able to pay legitimate fees to physicians as is constantly being done by this institution, then great harm is done, not only to the individual, but also to physicians and to the community. To give at public expense that for which the individual is able to pay is an ultimate harm, notwithstanding the fact that to some it may appear to be an immediate good. It is not a charity to provide for those who are able to provide for themselves because it relieves those individuals of a part of their obligations in life which it is

their duty to fulfil. It certainly needs no argument to show that mistaken charity of that kind, if carried to any extent, must inevitably lead to decadence of the people.

The direct harm done the medical profession by an institution of this kind cannot be overlooked, nor is it an evidence of selfishness on the part of physicians to attempt to defend themselves against such gross injustice. If it be admitted —and we think no one will attempt to deny it—that men possessed of superior medical knowledge are essential to the welfare of the community, it must be granted that anything which is detrimental to the profession unless it contribute to the public good—such as all forms of preventive medicine, etc.—must be detrimental to the community as a whole. It is well known that the medical profession has always been foremost in every thing which would in any way contribute to the prevention of disease and human suffering, and it has never failed to respond willingly and freely to the needy sick, but it should not be forgotten—which sometimes seems to be the case—that it costs more time, effort and money for a physician to become competent in his profession, and to keep up with the rapid advancements of knowledge, than it does one in any other line of human endeavor. Such an investment is certainly entitled to a reasonable return. No business man would think of putting the same amount of energy and money into an enterprise without the hope and expectation, and in fact without the certainty so far as business acumen could figure out, of ample financial returns. Why then should a group of business men themselves engaged in lucrative pursuits deliberately attempt to deprive medical men of a legitimate return on their investment? They are hiring young physicians and paying them compensation for their services, which they then give or sell for a nominal price to many who are able to pay a legitimate fee to regular physicians. We grant that they believe they are doing that which is for the public good, but we believe that if they will analyze the question in all its sociological aspects that they will see their error. It is neither charity nor is it justice to take from one class that to which they are entitled and give it to those who are undeserving of it. Much more might be said concerning the character of the work done by this institution and its harmful effect on the community in general, but we believe that sufficient facts have been brought out to warrant us in expressing our opinion that the said institution is—and

similar organizations are—acting against public policy and therefore cannot be considered ethical. There is no difference in principle between lawful and unlawful and ethical and unethical. That which is unlawful cannot lawfully advertise its business, and that which is unethical cannot ethically advertise its business, be the wording of the advertisement what it may.

Respectfully submitted.

M. L. HARRIS, Chairman,
RANDOLPH WINSLOW,
WILLIAM S. THAYER,
I. C. CHASE,
J. N. HALL,
A. R. CRAIG, Secretary.

Report of the Council on Medical Education and Hospitals

To the Members of the House of Delegates of the American Medical Association:

In its present report, the Council is referring to (a) the improvements made in undergraduate medical education up to the present time, (b) new problems which have arisen in medical education including the need of better facilities for graduate school instruction, and (c) work of the year by the Council in the organization of hospitals including a statement regarding out-patient departments, dispensaries and group clinics.

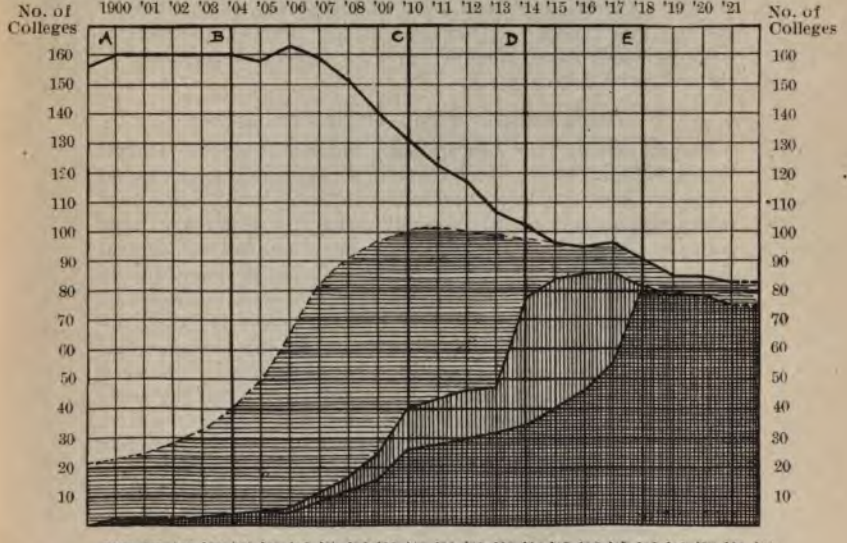
I. Present Status of Medical Education

As shown in previous reports following the close of the Civil War the number of medical schools rapidly increased until in 1906 there were 162 in the United States or more than were to be found in all the rest of the world. The educational standards, however, in 1906 were considerably lower than those in other leading countries. Based on this information, the Council in 1906 ascertained that the need was for "fewer but better medical schools." One of its first measures, therefore, was to urge (a) the general adoption of higher standards for admission and (b) the merging of medical schools in cities where two or more existed. During the eighteen years since the Council was established, therefore, the number of medical schools has been reduced from 162 to eighty-two. This was largely through the merging of from two to seven colleges into one invariably stronger institution in a score or more of cities. At the same time, a number of seriously low-grade colleges were closed outright. Along with the rapid reduction in medical colleges there was a correspondingly rapid increase in the number of colleges putting into effect the higher entrance requirement, where, in 1904, only two medical schools were requiring any college work for admission. At the present time, however, seventy-five out of the eighty-two medical schools are requiring two or more years of college work for admission—which makes the entrance requirements of medical schools of the United States equal to or slightly in advance of those in other countries. These changes are graphically shown in Chart I.

CHART 1.—FEWER BUT BETTER MEDICAL SCHOOLS

Although the total number of medical schools has been reduced, the number of those holding reasonably high entrance requirements has been greatly increased.

The total number of medical colleges each year is shown by the heavy descending line at the top. The light horizontal shading shows those which actually required a four-year high school education for admission; the vertical shading, those which required one year of collegiate work, and the heavy shading, those which required two or more years of collegiate work for admission.



	1900	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19	'20	'21	'22
Colleges	160	160	160	160	160	158	162	159	151	140	131	122	118	107	106	96	95	96	90	85	85	83	82
High Sch.	158	158	158	157	156	153	156	148	135	116	91	80	72	60	24	12	10	10	9	6	6	7	7
1 Yr. Coll.	..	..	..	..	..	..	1.	2	5	8	13	14	16	16	44	44	38	30	1	..	..	..	..
2 Yrs. Coll.	2	2	2	3	4	5	5	9	11	16	27	28	30	31	34	40	47	56	80	79	79	76	75

Five epochs, or stages, in the campaign for improvement are indicated in the above chart. In 1900 (A) the Journal of the American Medical Association began collecting and publishing educational statistics. In 1904 (B) the American Medical Association created a permanent committee, the Council on Medical Education. In 1910 (C) the Carnegie Foundation for the Advancement of Teaching published its report on medical education. January first of that year, also, had been designated by the Council as the date when medical schools should put into effect the entrance requirement of one year of collegiate work. This was not made an essential for the Class A rating, however, until (D) Jan. 1, 1914. The entrance requirement of two years of college work was made an essential for the Council's Class A rating (E) Jan 1, 1918.

While this chart refers mainly to the increase in entrance requirements, that increase is paralleled by the improvements in other respects in medical schools. For example, there has been a corresponding increase in the number, size and character of medical school buildings. The endowments for medical education have been rapidly increased. There has been an increase in the number of well-equipped laboratories; in the number of all-time expert teachers; in the amount of clinical material in dispensaries and hospitals—and of even greater importance—an increase in the number of medical schools which have adopted greatly improved methods of clinical instruction.

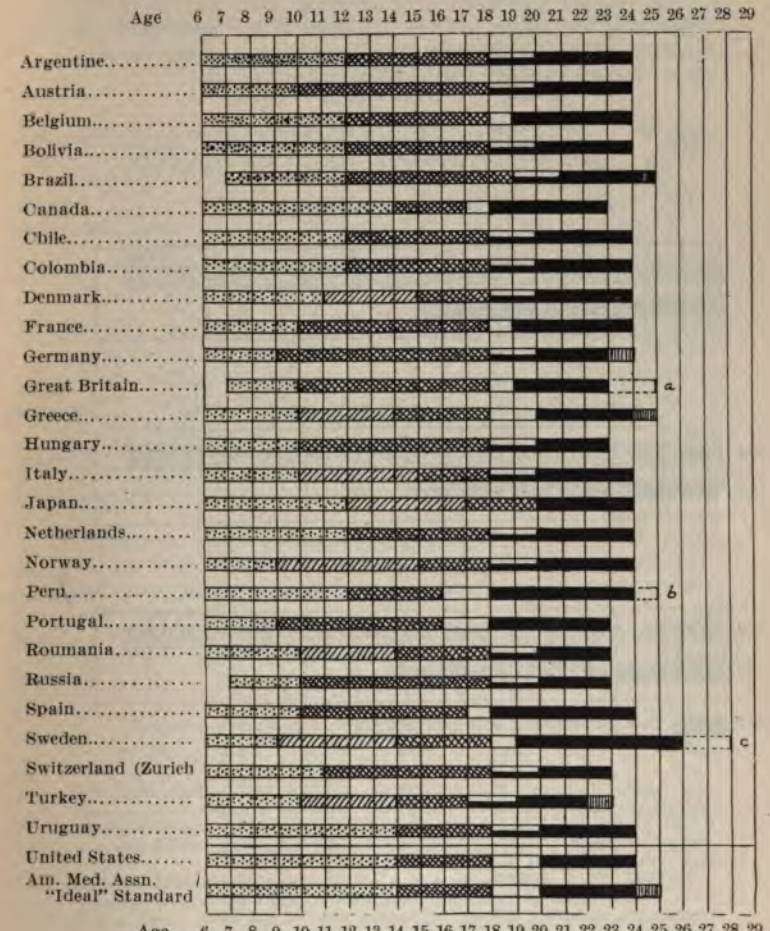
A COMPARISON WITH COUNTRIES ABROAD

A comparison of educational standards in the United States with those of other leading nations is graphically set forth in Chart 2. It is interesting to note that the line representing the age of 18 commonly separates secondary from collegiate education. In many of the countries of central Europe graduates of the secondary school go immediately into medicine. As is generally known, however, the work of the secondary schools of central Europe covers not only the work in the high schools of the United States but also that included in one and two years of college work. Between one and two years of time in this country is lost in the eight grades devoted to grammar school education. This, however, is being corrected by a rapidly increasing number of grammar schools in which students above the average are permitted to skip one or two grades and in that way are enabled to enter college at 16 or 17 years of age. The requirement of two years of college work, therefore, places medical education in this country on a par with the leading nations of central Europe.

BETTER QUALIFIED STUDENTS AND GRADUATES

With the merging of medical colleges and the general adoption of higher entrance requirements, a decrease in the number of students was expected. With the large oversupply of medical schools in 1904 there was a correspondingly large over-supply of medical students. It is not surprising, therefore, that the total number of medical students, which was 28,142 in 1904, decreased to 13,052 in 1919. It is gratifying to note, however, that the number of students in medical colleges which adopted the higher entrance requirements has increased from 1,761 in 1904 to 14,319 in 1921.

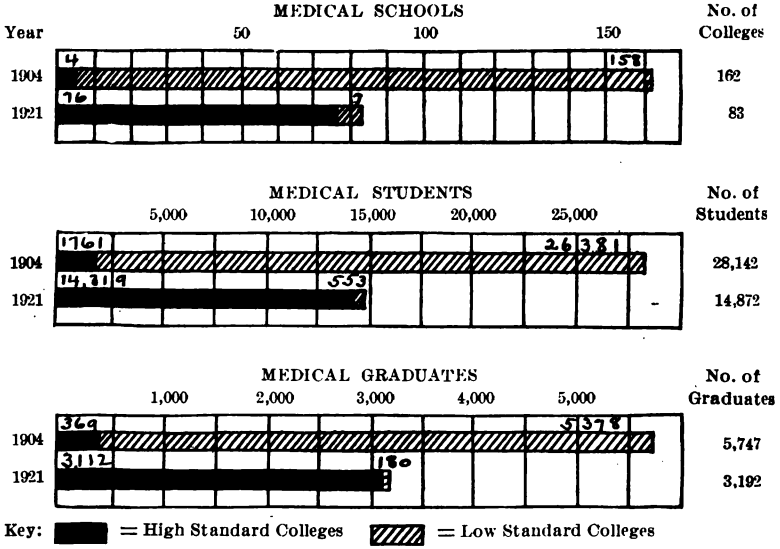
CHART 2.—PRELIMINARY AND MEDICAL EDUCATION IN THE UNITED STATES AND ABROAD—1920



a = Average time required to complete the medical course is 6 or 6½ years.
b = Some reports say medical course covers 7 years.
c = Average time required to complete the medical course is 8 or 9 years.

The number of students graduating also was decreased from 5,742 in 1904 to 3,192 in 1921—but at the same time, the number of those graduating under the higher entrance requirements increased from 369 in 1904 to 3,112 in 1921.

CHART 3.—QUALITY VS. QUANTITY OF MEDICAL COLLEGES, STUDENTS AND GRADUATES



In 1904 only four medical schools required any college work for admission, while 158 (97.5 per cent.) required at most only a high school education. Now 76 medical schools require two or more years of college work for admission and only 7 (8.4 per cent.) still hold to a high school education or less.

In 1904, 1,761 students were enrolled in the high standard colleges, while 26,391 (93.8 per cent.) students were enrolled in the low standard institutions, including a large proportion who did not have a high school education. Now 14,319 students are enrolled in high standard schools, while only 553 (3.9 per cent.) are enrolled in schools having low or loosely enforced entrance requirements.

In 1904, there were only 369 students graduated from the high standard colleges, while 5,378 (93.6 per cent.) were turned out by the lower type institutions. This year, 1921, 3,112 students graduated from high standard medical schools, while only 180 (5.6 per cent.) were turned out by the lower grade institutions.

TABLE 1.—QUANTITY VS. QUALITY

	Entrance Requirements				
	Two Years of College Work		High School or Less		
Medical Colleges:	No.	%	No.	%	Totals
1904	4	2.5	158	97.5	162
1921	76	91.6	7	8.4	83
Students:					
1904	1,761	6.2	26,391	93.8	28,142
1921	14,319	96.1	553	3.9	14,872
Graduates:					
1904	369	6.4	5,378	93.6	5,747
1921	3,112	94.4	180	5.6	3,192

The enrolment of students by classes during the last eight years is shown in Table 2. The lowest enrolment resulting from higher entrance standards began with the freshman class entering in 1914, culminating in the lowest number of students in all classes in 1918-19. A secondary wave of low enrolments began with the freshman class entering during the World War year, which will culminate in the smallest number of graduates at the close of the present session.

TABLE 2.—ENROLMENTS OF MEDICAL STUDENTS FOR EIGHT YEARS, SHOWING VARIATION IN NUMBERS BY CLASSES

College Session	Freshmen	Sophomores	Juniors	Seniors	Intern Year	Totals
1914–15	3,373	3,919	3,675	3,864	...	14,891
1915–16	3,582	3,094	3,559	3,727	...	14,022
1916–17	4,107	3,117	2,866	3,674	...	13,764
1917–18	4,283	3,521	2,893	2,933	...	13,630
1918–19	3,104	3,587	3,272	2,967	122	13,052
1919–20	4,234	2,837	3,464	3,263	290	14,088
1920–21	4,825	3,588	2,637	3,416	406	14,872
1921–22*	5,296	4,278	3,359	2,602	432	15,967

* Estimate.

The heavy line drawn through the table underscores the figures which show the lowest ebb in the enrolment in the respective classes following the adoption of higher entrance requirements. A temporary diminution in the numbers began with the freshmen in 1918-19 which was due to the enlistments in the World War. While the figures for 1921-22 are estimated they are fairly accurate since reports from all but a few colleges were obtained.

Since 1919, the enrolment has increased by about 1,000 students each year, reaching a total of 15,967 in the present session—the largest number since 1914.

II. NEW PROBLEMS IN MEDICAL EDUCATION AND PRACTICE

From the above it will be seen that tremendous improvements have been made in medical education during the last twenty years. Our medical schools are now in position to teach the greatly enlarged knowledge of medicine developed since the days of Pasteur and the era of medical research which began at that time. Medical education has indeed been revolutionized. Instead of a simple course of didactic instruction, the medical school now has an enlarged plant with its laboratories, library and museum, as well as the enlarged clinical departments including dispensary and hospital. These changes and the character of the education furnished, however, are in turn bringing about a revolution in the practice of the healing art. Indeed, several more or less serious problems have resulted largely, if not entirely, from the modern training now furnished to medical graduates, including the year of experience as an intern in a modern hospital. Some of these problems are as follows:

(a) Medical schools are finding it necessary to limit the enrolment of students.

(b) The cost of furnishing a medical education has been tremendously increased.

(c) There is an increasing trend toward specialization and group practice of medicine.

(d) There has developed a complaint regarding the lack of general practitioners, especially in the sparsely settled or rural districts.

(e) There is a rapid increase in the number of hospitals which brings a greater demand for interns than can be supplied from recent medical graduates.

LIMITATION OF ENROLMENTS IN MEDICAL SCHOOLS

A few decades ago the medical course consisted largely of didactic lectures and no limitation of enrolments was necessary. As classes grew larger, the size of lecture amphitheaters was increased, in many instances providing seats for

classes of 500 or more students. Even after laboratory courses were added, some schools provided enormous laboratories particularly in anatomy and chemistry and a few colleges had laboratories large enough in which to teach, at one time, several hundred including medical, dental and pharmacy students.

The medical curriculum has become more complex, however, and the teaching of students in small sections has become more general, especially in dispensaries and hospitals, so that a larger number of individual teachers is required, and administration is more difficult. To prevent confusion and to establish greater efficiency, therefore, it has become necessary

TABLE 3.—CAPACITY OF MEDICAL SCHOOLS UNDER LIMITED ENROLMENTS

Class A Medical Colleges:	No. Colleges	Total Enrolment 1st Year	2d Year	3d Year	4th Year	Total Enrolments 4 Yrs.	Average Total Enrolment per College
4-year colleges.....	42	3,185	2,050	2,990	2,970	11,195	267
2-year colleges.....	5	165	165	.....	.....	330	66
Estimated highest capacity with efficiency:							
4-year colleges.....	14	1,145	1,005	930	900	3,980	274
2-year colleges.....	5	210	210	...	...	420	84
Totals, Class A colleges....	66	4,705	3,430	3,920	3,870	15,925	691
Class B colleges:							
Capacity reported.....	3	120	120	125	125	490	163
Capacity estimated.....	3	100	100	100	100	400	133
Totals, Class B colleges....	6	220	220	225	225	890	296
Totals, A and B colleges....	72	4,925	3,650	4,145	4,095	16,815	234

for medical schools to admit no more students than their teachers, laboratory space, and available hospital and dispensary facilities will permit.

At the present time, 47 medical schools are limiting the number of students admitted to each class, and report a total capacity for 11,925 students. The other nineteen Class A colleges have an estimated capacity for 4,400 students, making a total capacity in the sixty-six Class A medical schools for 15,925 students.

Sixteen of the Class A medical schools report that by adding several teachers, enlarging certain laboratories, or by other

minor modifications provision can be made for 1,500 more students. This would increase the capacity of the sixty-six Class A schools to 17,425 students—about 1,500 more students than are now enrolled in all existing medical schools including those in Classes A, B and C.

DO WE NEED MORE MEDICAL SCHOOLS?

The rapidly increasing numbers of well qualified students, coupled with the tendency of medical colleges to limit their enrolments, is causing some anxiety lest well qualified students will be unable to secure admission to acceptable medical colleges. To meet the situation it is important that some medical schools which have placed their limits at extremely low numbers—twenty-five or thirty in a class—shall enlarge their facilities so as to admit larger numbers. It would appear that a medical school with a complete corps of instructors should be able to handle from fifty to seventy-five students in a class. The enrolment of extremely small numbers also causes a large disproportion between the fees paid by the student and the—at the present time—much larger sum expended for his instruction. Public investigations are liable to be demanded of such large expenditures, especially if many well qualified students find they cannot secure admission to medical schools. If the numbers of well qualified medical students continue to increase, the existing medical schools must provide for them or new medical schools will need to be established. We cannot afford to have so limited a capacity in our better medical schools as to force well qualified students into lower grade institutions. It is believed that the present number of medical schools is sufficient but unfortunately some are not sufficiently financed to care for as large classes as otherwise might be enrolled. In this connection, it is pleasing to note the statement of Dr. Pritchett in his recent report, that instead of aiding "only a few great medical schools" such aid be extended "to strengthen weak schools" in other communities "that sincerely seek their own improvement." A few hundred thousand dollars distributed among these smaller but deserving medical schools in the present emergency will be of far greater service to the public than additional millions given to one of the few institutions which are already so generously endowed.

Number	Total
1	$616,08
2	577,09
3	443,72
4	439,00
5	317,18
6	298,16
7	270,10
8	267,09
9	256,44
10	256,33
11	206,45
12	200,51
13	186,70
14	179,91
15	178,66
16	173,24
17	168,13
18	161,10
19	156,56
20	148,11
21	133,30
22	132,13
23	129,47
24*	127,30
25	121,29
26	116,96
27	103,13
28	101,85
29	100,00
30	99,56
31	97,28
32	96,55
33	93,82
34	90,44
35	89,24
36	88,00
37	86,72
38	85,15
39	84,50
40*	79,53
41	77,18
42	76,15
43	75,28
44	74,90
45	71,50
46	66,22
47	64,50
48	63,00
49	62,34
50*	61,47
51	58,50
52	56,23
53	55,87
54	55,50
55	55,13
56	54,72
57	53,80
58*	50,90
59*	50,50
60	44,85
61*	35,00
62*	34,19
63*	32,57
64*	27,25
65	23,67
66	21,57
67*	21,22
68*	20,60
69*	17,70
Totals	$9,016,35
Average	$130,67

* Institutions
1. Students' fe
2. Total sum
3. Includes $6,

THE INCREASED COST OF MEDICAL EDUCATION

During the last twenty years the cost of conducting medical schools has been tremendously increased. Buildings have been enlarged, making necessary a greater cost for lighting, heating and janitor service. A larger expenditure is necessary for administration, for records and for clerical assistance. The increased number of laboratories has correspondingly increased the cost for equipment and maintenance. A larger expenditure is required also for medical research, for the maintenance of library and museum and—unless provided by city, state or private benefactors—for dispensaries and hospitals. The largest single item, however, is the expenditure for salaries paid to the essential expert instructors who devote their entire time to teaching and research in the laboratory departments. If the salaries now paid by several medical schools for full-time professors in the clinical departments are included the expense for this item is still further increased.

It is not surprising, therefore, that the cost of furnishing a medical education at the present time is nearly four times the income obtained from students' fees, even though these fees have been increased to a moderate extent.

Reports from sixty-nine medical schools in regard to income and expenditures for the last fiscal year show that the average income was $130,672 including $35,135 (26.9 per cent.) obtained from students' fees, and $95,537 from other sources.

The average expenditure by each college was $123,947 including $46,162 (37 per cent.) for all-time teachers, $21,131 (17 per cent.)—(54 per cent. for instruction) for part-time teachers, $19,068 for wages and $36,974 for maintenance and supplies.

Of these sixty-nine medical schools the average yearly fee obtained from each student was $185 and the average amount which the medical school expended in order to furnish his instruction was $655. In 1916, the average fee paid by each student in eighty-two colleges reporting was just $150, and the average expenditure per student was $419. In the five years, therefore, the average expenditure per student has increased 56 per cent. while the tuition fee has increased only 24 per cent.

The reports from the various medical colleges, indicated by number, are shown in Table 4.

DANGERS FROM SPECIALIZATION

In recent years the number of physicians entering the specialties has been increasing. This is a normal process which naturally follows the enlargement of the field of medical knowledge. Prior to 1900, physicians became specialists usually after several years of general practice, and often after a postgraduate course in Europe.

With the present wide fields of medical knowledge and practice, no one can secure the highest degree of efficiency and skill in diagnosis and treatment unless he limits his practice to some special field of medicine.

The need of highly skilled specialists was very pronounced during the World War when they were in such great demand. Specialization, if based on a satisfactory training in both the fundamentals of medicine and in special work, is in the interests of the public and worthy of commendation.

The trend toward specialization at present appears to be overrapid and the importance of the specialist has been exaggerated to the detriment of the general practitioner. Recognizing this fact, the Council at its recent conference discussed the desirability of reorganizing the medical curriculum so as to include in the undergraduate curriculum only such courses as are necessary to prepare the graduate to be a good general practitioner leaving all special training for the postgraduate school.

Another danger from a too rapid development of specialization is that physicians may declare themselves to be specialists without having secured the thorough additional training necessary to justify them in so doing.

It is evident from a study of this whole problem that provision should be made by the stronger medical schools of the country to provide thorough courses of graduate instruction for the specialist. It is hoped, also, that the state licensing boards will soon demand such thorough training before any physician is permitted to pose as a specialist.

MIGRATION OF PHYSICIANS TO CITIES AND NEEDS OF RURAL COMMUNITIES

There has always been a scarcity of physicians in rural communities but the situation became especially acute during the World War since many physicians left those districts to enter the government medical services and did not return after their discharge. Many of these took the opportunity

to secure a postgraduate training preparatory to entering a specialty. The places in the rural communities, furthermore, have not been filled by recent medical graduates, who during the last several years have been less inclined to locate in rural districts than formerly.

Recent statistics show that physicians are following the general trend of the population toward the cities rather than to locate in rural districts but in a larger proportion. According to the 1920 census reports, 47.1 per cent. of the population of the United States is now contained in cities of 5,000 and over leaving 52.9 per cent. in communities of less than 5,000 people. According to the 1921 edition of the American Med-

TABLE 5.—URBAN OR RURAL POPULATION AND SUPPLY OF PHYSICIANS

Population of Cities [1]	No. of Cities	Total Population	Per Cent. Population	Number of Physicians [2]	Ratio of Physicians to Population	Percentage All Physicians
500,000 and above	12	16,369,310	15.5	30,932	529	21.0
200,000 to 500,000	21	6,353,645	6.1	12,862	493	9.0
50,000 to 200,000	111	9,973,462	9.4	17,254	578	12.0
10,000 to 50,000	602	12,017,783	11.4	21,204	563	15.0
5,000 to 10,000	721	4,997,794	4.7	9,313	527	6.0
Below 5,000.....	...	56,153,587	52.9	54,043	1,020	37.0
Totals.....	...	105,708,771	100.0	145,608	726	100.0
Totals in cities of 5,000 and over.....			47.1	91,565		

1. Population figures based on report of the Census Bureau for 1920.
2. Figures regarding the numbers of physicians are from the American Medical Directory for 1921.

ical Directory 63 per cent. of the physicians of the United States are located in cities of 5,000 or more people, and 37 per cent. in cities and communities of less than 5,000.

From these figures it will be seen that the scarcity of doctors in rural communities is not due to a general shortage of physicians, since the scarcity in rural communities is more than offset by the oversupply in the cities. There is, therefore, no call for special methods to swell the ranks of the medical profession. As has already been shown, also, the numbers of medical students, even under the higher entrance requirements, are becoming so large as to make it difficult for medical schools to care for them. There is, therefore, no need for a retrogression in educational standards.

The causes for the shortage of physicians in rural communities are (*a*) the progress in sanitation and disease prevention has reduced the amount of sickness in the country as well as in the city; (*b*) interurban cars, improved roads, the automobile and other means of rapid transit are working against the country doctor in that well-to-do people are going more and more to physicians in nearby cities; (*c*) this leaves for the country physician only the emergency cases and those who are unable to pay reasonable fees; (*d*) practice in the country, therefore, brings a minimum income for a maximum effort; (*e*) the physician, like others, prefers to live in the city with its better schools, better living conditions, etc.; (*f*) last, but not least, comes the better facilities for the practice of modern medicine in hospitals which, at present, are found only in the cities.

NEED OF THE HOSPITAL IN PRACTICE

Over ninety per cent. of all recent graduates in medicine now secure hospital intern training before entering on the practice of medicine; they are accustomed to the use of the modern aids for the diagnosis and treatment of diseases which are found in hospitals and know the value of the hospital routine in the treatment of patients. The benefits of hospital care are coming more and more to be recognized by the public, also, which explains why many well-to-do people in the country come to the cities for treatment. The solution of this problem, therefore, is to have a hospital built in every community where there are enough people to support it. This hospital would enable three or more physicians to care for the patients in the immediate community and through the better roads and the automobile could promptly reach patients in even outlying districts. In connection with this central community, outposts might also be established in smaller, outlying localities, where a physician of the staff might keep hours at regular intervals. This would enable him to look after the general needs of that community; to recognize cases requiring hospital attention and to arrange for the needed care. The solving of this problem does not mean retrogression in either educational standards or methods of practice; it means the recognition of new conditions in medical practice and the establishing of community hospitals whereby these improved methods will be brought within the reach of all the people, those in the smaller towns and rural communities as well as in the cities.

THE UNDERGRADUATE MEDICAL COURSE

At the Council's conference in March a revision of the undergraduate curriculum was suggested in a report prepared by Dr. Ray Lyman Wilbur, an abstract of which follows:

The essential aim of the undergraduate medical curriculum is to train a student already versed in laboratory methods so he will know how to "practice medicine." The graduate in medicine should have a large fund of immediately available anatomic, physiologic and clinical information; his sense organs should be well trained and as many facts as possible should be gathered together and given an orderly relationship. The specific problem is the development of the student's powers of observation and of rapid, honest, unbiased reasoning, based on ascertained facts.

A trained clinician on entering the sickroom has every sense alert. His eye takes in at a glance the surroundings of the patient, the evidences of care or lack of care, anxiety, repose, cyanosis, jaundice and a hundred other conditions. His ear tells him of voice changes, types of breathing. His nose adds its share; and when he touches the patient or percusses the chest, a combination of all the senses helps him to build up a mental picture of the processes going on inside the human body which years of training have taught him to know so well. All the time his mind is busy arranging the facts ascertained, calling up former experiences, measuring values, reaching conclusions, mapping out plans for additional methods of seeking information and preparing a method of treatment. When well done, such work represents the height of ordinary human achievement, and at times seems to bear the evidences of genius.

The object of the undergraduate medical years is to lay the basis for such work in medical practice. You can call it the art of medicine or the science of medicine; the two merge into one in real medical work, and a skilled technician must be the result. The main reason the present undergraduate course often fails is that we have tried to force into four short years the enormous and constantly growing fund of medical knowledge, and time should not be wasted on giving prolonged descriptions of very rare medical conditions.

The present curriculum was built up at a time when clinical teachers had no confidence in the basic training of the student, and they felt impelled to repeat fundamentals and reorient students in each so-called "course." In most med-

ical schools even today the medical student is taught the general phenomena of inflammation by from three to fifteen teachers in different subjects. Repetition of elementary work, duplication and lack of coordination, too much informational material and rigid legal hour requirements have made the present medical school a wonderfully intricate mechanism of hours, schedules, lectures, courses, that has become scrambled, mixed up, unwieldy and inefficient. Why not scramble it entirely, look carefully over the mass, pick out the fundamentals and get a fresh start? The good preliminary training now required of medical students has eliminated many of the unfit. They now have a training in the basic sciences, and are able to do an increasing amount of independent and thoughtful work.

The fundamentals with which students must now concern themselves are: (1) sound basic training in methods of thought, memory and honest reasoning; (2) the ability to observe; (3) the ability to use books and the tools of the profession; (4) the retention of a sound body with acute trained senses, and (5) the mental accumulation of essential facts immediately available for use.

To best utilize the four brief medical years, we need in some way in training the student to combine the old apprentice system with the modern laboratory. A common standardized course for all medical schools is no longer necessary. The central core of information needed by the doctor should be selected and supplemented by the needed technical training, letting industry, books, open eyes and willing minds complete the work.

The central core of medical training must include anatomy, physiology, chemistry, bacteriology, pathology, pharmacology, clinical and laboratory medicine, including pediatrics and mental diseases, clinical and laboratory surgery, obstetrics and gynecology, hygiene and public health. We can add for good trimming the history of medicine and medical jurisprudence. If these subjects are adequately taught there will be no need to include the specialties except in an elementary way. The professors of medicine and surgery can readily bring the essentials of every specialty into their routine teaching. The student can be left time enough for optional work in his four years so that he can enter any chosen special field for additional technical training. If he learns how to examine thoroughly a single patient, he will have the principal tools and information required.

The specialties, taught as they are at present, belong outside the undergraduate medical curriculum. They can be included in the medical curriculum when they are taught by men who can range over the body instead of having their vision limited largely to body orifices. It would not be so absurd to spend a whole schedule hour of an undergraduate medical class on the technic of an operation on the inner ear, if other more important things to the student—perhaps not to the professor—were not so pressing. It must not be forgotten, however, that any complete observation and any piece of highly skilled work has its value in instruction.

Instead of elaborating new schedules, it is suggested that the number of hours allotted to the specialties be reduced or, better yet, that all specialists be promoted to the graduate school but continue to join in the teaching of the main clinical branches by presenting cases, giving lectures or, better still, by demonstrating their special field of work on patients already familiar to the students.

Pediatrics is not a specialty but is general medicine with an age limit, and offers the most important source of training for the medical student in physical examination, nutrition, therapeutics and hygiene.

Without emphasizing details, my suggestions are: (1) Begin some clinical work as early in the medical courses as is physically possible to heighten the interest of the student and give him a sense of professional training; (2) divide the last two years between general medicine and pediatrics, including mental diseases, 40 per cent.; general surgery, 30 per cent.; obstetrics and gynecology, 10 per cent.; hygiene and public health, from 5 to 10 per cent.; optional work, such as special work along general lines, thesis, work in special fields, medical jurisprudence, history of medicine, etc., from 15 to 10 per cent; (3) bring the laboratories into immediate conjunction with the clinics so that the eye of the student, still bearing the image of the anemic appearance of a patient, may see his red blood cells; (4) have the clinician cross over freely into the domains now sacred to the specialists, bringing in the specialists to help him; (5) have a committee on coordination of course content with regular reports of the ground covered by teachers to avoid duplication and to see that each class is exposed to a sufficient amount of well balanced and selected information; (6) make hospital experience with responsibility a requirement for graduation either by the intern year or by some other device.

One responsibility well met, no matter what the pathologic condition, is of more value in medical training than a dozen carefully dehydrated lectures; (7) since all medical practice is of the nature of research and medicine is constantly growing, keep the spirit of research active all along the line in the medical course.

FUTURE DEVELOPMENT OF MEDICAL EDUCATION

At the last Annual Conference on Medical Education in March, Dr. Arthur Dean Bevan presented a constructive program for the future development in medical education from which the following summary is taken.

The ultimate object of medical education is to secure to every individual the great benefits of modern scientific medicine. Medicine is one of the great factors of modern civilization and in its future development proper regard must be given to its relationship to the community, to the profession and to general education.

In the last (the 1921) report of the Carnegie Foundation, President Henry S. Pritchett, who for many years has been a close and sympathetic student of medical education, says:

"The primary purpose of the medical school is to train practitioners for the medical profession. There are many by-products of this primary intention but . . . these by-products will be greatest when the medical school conceives most clearly its fundamental purpose and bends its effort most directly to it. While the development of a highly trained profession, like that of medicine, is directly dependent on the character of its professional school, and while it is essential that the professional school shall keep clearly in view its primary purpose it is none the less essential that medical education shall keep in touch with the changing needs of the profession. To do this it must take into account those agencies of professional training that are closely related to its field of service. Without this contact it is entirely possible for the profession to be educated away from a sound conception of its immediate needs and the steps by which they are to be met. It is essential that those who have to do with the medical school shall conceive of it not only in respect to its primary purpose, but also in relation to those institutions and agencies with which the training of the medical profession is so intimately connected."

Medicine is the science and art of healing; therefore, the study of medicine is the study of the science and art of heal-

ing. It is the study of the sick or injured patient. Because of that fact the medical school should be located in and about the hospital and the dispensary, because it is there that we can best have access to the patient who is the object of study. It is a fundamental proposition, therefore, that the medical school should be centered in and about the hospital. The laboratories and class rooms used to teach the daughter sciences of anatomy, physiology, pathology and pharmacology should be grouped about the hospital and dispensary.

The expense of conducting a hospital large enough for a teaching hospital for a medical school is very great and it should not be borne by the medical school. The primary function of a hospital is to care for the sick; its secondary functions are teaching and research. In serving its primary purpose it is doing an essential function in the community and its cost should properly be borne by the community which it serves. About the hospital should be built the laboratories of pathology, anatomy, physiology and pharmacology, so that these departments may keep in touch with the clinic and clinical problems.

In addition to the teaching hospital there should be an outpatient department, which is very essential in medical teaching, and a diagnostic clinic—such a plant as the Mayo Clinic building, where the staff of the hospital can have their consultation and examining rooms, clinical laboratories and every facility to examine and care for pay out-patients. The time has come when we should recognize such a diagnostic clinic as one of the most essential plants in our medical school scheme.

In regard to the medical curriculum proper, President Pritchett in his report says:

"The reform of the curriculum of the undergraduate medical school is one of the most pressing questions of present day medical teaching, and its accomplishment will have a larger bearing on the progress of the profession than any other single action. . . . The medical student takes up the study of certain fundamental sciences, anatomy, physiology, pathology, chemistry (pharmacology), on which he undertakes to build the superstructure of professional training. The applications of medical science have, however, become so varied and so complicated that the medical student is not only called on to carry an impossible load, but also his fundamental sciences are in different compartments from the applications which ought to illustrate and make clear the

sciences themselves. The student learns anatomy by a tedious process of dissection on which he spends a large amount of time, but he has a very good opportunity to forget most of it before he sees, in practice, the application of his anatomical studies. These fundamental sciences can be taught, not as something separate from medical practice but as part of it. . . . It must be clear to every medical teacher that the weakest parts of the present medical teaching are the courses in anatomy and pathology. These are elaborately taught to every medical student without affording him any opportunity to see the application of anatomical and pathological knowledge to the practice of medicine and surgery. The process is like teaching forestry by giving the student elaborate courses in botany before taking him into the forest. . . . The practical remedy for this situation is to reduce the amount of theoretical instruction in the first two years, and to change the character of the teaching so as to make clear the fundamental facts, while at the same time starting the clinical instruction at the very beginning of the course. The student should learn his anatomy and his pathology through his clinical training, not reverse the process. No other reform in medical teaching approaches in importance this one."

In reorganizing the medical curriculum we must recognize the fact that the medical school should provide for the training of two classes of medical practitioners — the general practitioner and the specialist and must provide both an undergraduate and a graduate course of instruction. The clinical instruction in the undergraduate course should be broadened and simplified and given under the three departments of medicine, surgery and obstetrics, and by teachers who are broadly trained and who in their clinical work cover the entire patient. Research is an essential integral part of every well organized clinical department. ~~It is absurd in a medical school to create a special department of medical research. From their very organization, such departments are almost certainly doomed to sterility.~~ Whatever funds there are in the control of the medical school which can be used for research should be intelligently assigned to the various laboratory and clinical departments with the certainty that these funds will be of much more service to the school and the science of medicine than they would be if they were used to develop a special research department or laboratory.

In the interests of medical education and for the protection of the public, all medical schools and state medical boards should make the hospital year a requirement both for graduation and for the license to practice.

Another important matter is the providing of thorough courses for the training of specialties. The reports of the committees presented at the annual conference in 1921 brought this whole matter clearly before the medical profession and the medical schools. The medical schools are again urged to make provision for the training of specialists and also to provide postgraduate courses for medical practitioners.

Those who have been studying this problem in a broad way recognize that the ultimate aim of medical education must be to secure the benefits of modern scientific medicine to all the people. The time has come when the medical profession must take the initiative and organize the entire profession so as to secure this result. This is a national problem, a state problem and a community problem. In its practical application, however, it is a community problem. In every community which can support them we should have the necessary number of well trained medical men; we should have properly built, properly equipped and properly conducted hospitals which can furnish the hospital and diagnostic facilities demanded by modern scientific medicine sufficient for the needs of that community. Such medical facilities are as necessary in our modern civilization as good roads and good schools. By an educational propaganda, we must make this clear to the profession and the people. The American Medical Association must point out the way and urge every county medical society to make this work their first and most important function.

PROBLEMS OF MEDICAL LICENSURE

As the admission requirements of medical schools have been advanced during the last seventeen years the requirements of preliminary education by state licensing boards have also been advanced and progress has been made in medical licensure as indicated by Table 6, reproduced herewith. This shows, therefore, that standards of medical licensure have been generally improved.

There are a number of problems, however, shown in the recent State Board Number of THE JOURNAL[1] to which the attention of the House of Delegates should be called. One

1. Jour. A. M. A. **78**: 17, April 29, pp. 1297-1319.

of these is the continued existence of separate eclectic boards in Arkansas and Connecticut, through which those states are being flooded by graduates of low grade medical schools.

TABLE 6.—ADVANCES IN STATE LICENSE REQUIREMENTS IN SEVENTEEN YEARS

Requirement or Provision	States Having Provision for			States Still Having No Provision for
	1904	1922	Increase	
Preliminary Education—				
Any requirement	20	47	27	3[1]
A standard four-year high school education or higher	10	47	37	3[1]
One year or more of college work	0	42	42	8[2]
Two years of college work as a minimum	0	38	38	12[3]
That all applicants be graduates of a medical college	36	49	13	1[4]
That all applicants undergo an examination for license	45	49	4	1[4]
Requirement of practical tests in the license examinations	1	13	12	37
Hospital intern year required	0	10[5]	10	40
Full authority by board to refuse recognition to low-grade colleges	14	47	33	3[6]
Boards refusing to recognize low-grade colleges	5	47[7]	42	3[8]
Reciprocal relations with other states	27	44	17	6[9]
Single boards of medical examiners	36	45	9	5[10]

1. District of Columbia, Massachusetts and Wyoming.
2. See Table L.
3. Colorado.
4. New Mexico.
5. Pennsylvania, 1914; New Jersey, 1916; Alaska, 1917; Rhode Island, 1917; North Dakota, 1918; Washington, 1919; Illinois and Michigan, 1922; Iowa, 1923, and Texas, 1924.
6. District of Columbia, Massachusetts and Wyoming.
7. In two states, Arkansas and Connecticut, each of which has three separate boards, only the regular (nonsectarian) boards have refused recognition to low standard medical colleges and have enforced higher standards of preliminary education.
8. The states named in Footnote 6.
9. Alaska, Arizona, Connecticut (regular board), Florida, Massachusetts, Rhode Island. To this list should be added the outlying territories of Canal Zone, Philippine Islands and Porto Rico, which have no provision for reciprocity.
10. Multiple boards still remain in Arkansas, Connecticut, District of Columbia, Louisiana and Maryland.

Another is the licensing of osteopaths as physicians and surgeons by several boards—notably, California, Colorado and Texas. The numbers so licensed in these states during the last five years are shown in the footnotes to Table 7, inserted

TABL

	State
1	Alabama.....
2	Arizona.....
3	Arkansas.....
4	California.....
5	Colorado.....
6	Connecticut...
7	Delaware.....
8	Dist. Columbi
9	Florida.....
10	Georgia.....
11	Idaho.....
12	Illinois.....
13	Indiana.....
14	Iowa.....
15	Kansas.....
16	Kentucky.....
17	Louisiana.....
18	Maine.....
19	Maryland.....
20	Massachusetts.
21	Michigan.....
22	Minnesota.....
23	Mississippi.....
24	Missouri.....
25	Montana.....
26	Nebraska.....
27	Nevada.....
28	New Hampshir
29	New Jersey....
30	New Mexico....
31	New York.....
32	North Carolin
33	North Dakota.
34	Ohio.....
35	Oklahoma.....
36	Oregon.....
37	Pennsylvania..
38	Rhode Island..
39	South Carolin
40	South Dakota.
41	Tennessee.....
42	Texas.....
43	Utah.....
44	Vermont.....
45	Virginia.....
46	Washington...
47	West Virginia.
48	Wisconsin.....
49	Wyoming.....
50	U. S. Territorie and Possession
	Totals.....

1. Of the 132 gr during the last f of medical examin

2. During the were licensed in licensed as physic

3. Of the 106 C licensed with the

4. Illinois is th *accounts for the year.*

herewith. It is noteworthy that two of these states—Colorado and Texas—refuse to admit graduates of Class C medical schools to their examinations. Nevertheless, they admit graduates of osteopathic colleges, which are nothing more than very low type medical schools.

A third problem is the confusion which exists in the administration of medical practice laws caused by the various forms of "drugless" healing. As a result of this confusion there are misconceptions as to just what the practice of medicine is. By any logical manner of thinking, all methods by which human ailments are treated are covered by the term "the practice of medicine." It is evident that any one who is to treat human disorders by any method should have a knowledge of the fundamental medical sciences by which he can make a reasonably accurate diagnosis. It follows, also, that the educational qualifications required of one practitioner—the physician—should be required equally of all who profess to treat the sick. Legislators have at various times overlooked these facts, have listened to the claim of would-be healers that because they "did not use drugs," that they were "not practicing medicine" and have granted them authority to practice on lower qualifications than are required of physicians. Such action is illogical. That the practice of medicine is not limited to the giving or withholding of drugs, but includes any and every useful means of diagnosing or treating human disorders, has been repeatedly recognized by the national supreme court. In a Texas case[1] it was declared that osteopaths, like physicians, should be required to have a scientific training, and a clear distinction was made between osteopaths, on the one hand, and nurses and masseurs on the other. Osteopaths, it was implied, gave treatment without a physician's diagnosis or instructions, while nurses and masseurs performed their functions after a physician had ordered that treatment or care. The decision applies with equal force to any other class of healers. Recently a decision has been rendered by the United States supreme court which clears the atmosphere in Ohio. Chiropractors, it has been ruled, must secure licenses from the medical board, or they are subject to prosecution for practicing illegally. The various healers in bombarding the legislatures—too often successfully—to secure special privileges in regard to practice, have indeed caused confusion in medical licensure but the con-

1. Collins vs. State of Texas (U. S.) 32 S. c. Rep. 286.

fusion is beginning to be cleared away. The issue should be tested on the basis of reasonable educational qualifications, and then, if necessary, each case should be carried through to the United States supreme court where the merits of the situation will be cleared up. The forces for law and order in each state should not rest until one standard of educational qualifications has been established, which will be equally fair to the physician and to every one else who is authorized to practice the healing art. Even granting that there is some good in the methods emphasized by any group of healers, this good will in no way be diminished if those applying such methods are required first to have had a training in the fundamental medical sciences.

III. THE COUNCIL'S WORK WITH HOSPITALS

The work of the American Medical Association with hospitals began in 1904 when a list of all such institutions was prepared for publication in the American Medical Directory. The Association collected also a large amount of detailed information in regard to all hospitals. In 1904, also, the ideal standard of medical education proposed by the Council included, among other things, the requirement that a fifth year be spent by the student as an intern in an approved hospital. The Council began at once to collect data in regard to hospitals which were making use of interns. At that time, however, there were not enough hospitals using interns to provide places for all medical graduates and so far as they could get them students were obtaining internships voluntarily.

FIRST SURVEY OF HOSPITALS

In 1912 a circular letter was sent to the 2,424 hospitals having twenty-five or more beds asking in regard to the use of interns. Replies were received from 2,185, or 90 per cent., and only 852 were regularly using interns which provided places for 3,006 graduates. Since the internships in many hospitals extended over eighteen months or two years, the internships available annually were about 2,000 although approximately 4,000 students were graduating each year.

In 1913 a questionnaire was sent to all hospitals and on the basis of the reports received a provisional list was prepared of hospitals approved for intern training. This list was carefully checked by a committee of three prominent physicians in each state, unworthy hospitals were eliminated, and other hospitals which deserved to be included were added.

In 1914 this revised list was published and in 1915 a list of the Council's state advisory committees was published. In 1915 the members of all the state advisory committees on hospitals were selected by and made organic parts of the state associations.

SECOND AND THIRD SURVEYS

In 1915 a second questionnaire was sent to hospitals having fifty or more beds. Through the state committees, numerous inspections and investigations were made, so that the list of hospitals approved for intern training which was published in 1916 was more reliable than the previous lists. It was the only list available for the guidance of students seeking internships.

THE AMERICAN CONFERENCE ON HOSPITAL SERVICE

As the result of a resolution adopted at the annual conference on medical education in 1919 the American Hospital Conference was organized in Chicago in April of that year. At its first regular meeting held in Cincinnati in September, 1919, the name was changed to the American Conference on Hospital Service. This is an organization made up of representatives of fourteen organizations especially interested in the improvement of hospital service. The organization now has its part in the annual congress on medical education, licensure, public health and hospitals which has grown out of the annual conference of the Council on Medical Education. The annual meeting of this organization in Chicago last March was of unusual interest and service through the discussion of numerous hospital problems.

Early in 1918-1919 the third survey of hospitals was completed. As in previous surveys, the state advisory committees aided materially in the work. Detailed reports were received from 1,126 hospitals stating that they were using or seeking interns—274 more than were included in the list of 1912. The total bed capacity of these hospitals was 270,500, places were available for approximately 6,000 interns. It was evident that with only about 4,000 physicians graduating each year, all these hospitals could not be supplied with interns. This made it important to select more carefully the hospitals admitted to the approved list, so that the internship might be made a fifth year of actual clinical training for the student.

ENLARGEMENT OF THE COUNCIL'S DUTIES

At the meeting of the American Medical Association in 1920 the House of Delegates placed all the Association's work with hospitals in charge of the Council on Medical Education and Hospitals.

For the tremendous work that needs to be done for the improvement of hospital service, no organization occupies a position more advantageous than the American Medical Association with its various state organizations. The work of the Association with hospitals must take all institutions into consideration and the Council is planning to establish a list, not only of those approved for intern training but also of those approved as nonintern hospitals. The standard applied to intern hospitals is being modified so as to apply to both groups. It is becoming increasingly important that every community be provided with adequate medical and hospital service. So much depends on the future development of hospitals, therefore, that the members of each state committee should be selected with special care. It is urged, that a permanent committee be established in every state consisting preferably of three members serving for a term of three years, the first committee being so appointed that the term of one member will expire each year.

HOSPITAL WORK OF THE YEAR

The latest list of hospitals approved for intern training was published in the Hospital Number of THE JOURNAL, April 16, 1921, and also in the medical directory. The Council has kept in close touch with the hospitals either directly or through the state committees and has approved several other hospitals that have applied for admission to the list and removed a few others that have fallen below the standard. Since the list was last published 43 hospitals have applied for classification, and 17 have been approved. There are now 627 hospitals on the approved list, distributed as follows:

	Number Approved	Internships	Beds
General hospitals	495	2,994	108,741
State hospitals and hospitals for the insane	28	99	50,134
Other special hospitals	104	424	16,117
	627	3,517	174,992

Through the cooperation of the state committees every decision regarding a hospital's facilities for intern training

is now based on written evidence regarding the hospital's equipment, staff, character and quantity of work, and other items that go to make an internship.

The Council maintains also a general list of all hospitals for insertion in the directory and for the hospital information service. This phase of the work is followed closely because new hospitals are constantly being added and others are going out of existence, changing hands, increasing their bed capacity, etc. The time has passed when an occasional "roundup" of hospitals will suffice to provide the service that the Council is now called on to supply.

We wish to mention especially the splendid cooperation received from the state hospital committees which respond fully and promptly whenever requests for information or inspection are made. In a few states, notably California, Washington, Missouri and Ohio, and to a greater or less extent in other states, the committees have been particularly active and even aggressive, visiting hospitals and assisting in problems of staff organization or community relationships when requested by the hospital. In fact, the state committee organization throughout the country is now capable of being called into action to perform any important work and with a thoroughness hardly to be expected of voluntary committees.

SURVEY OF DISPENSARIES, CLINICS AND GROUP PRACTICES

There has developed in recent years a growing demand for information in regard to the number, distribution and work done in dispensaries, clinics and group practices, and during the present year the Council is making a special effort to obtain such data.

A comprehensive survey is now being made of all institutions that give medical service to ambulatory patients, including outpatient departments of hospitals; general dispensaries not connected with hospitals; group practices; tuberculosis; venereal, mental hygiene and other special clinics; health centers; baby welfare clinics, etc. It was found necessary to list all these various organizations in order to even approach completeness in any one of them.

The information thus far obtained indicates that there are in the United States, at the present time, approximately 1,150 outpatient departments, 800 independent dispensaries and possibly 200 group practices. Adding the clinics and dispensaries for tuberculosis, for venereal diseases, mental hygiene clinics

and baby welfare clinics, there are no less than about 4,500 institutions giving medical service to ambulatory patients. Returns are constantly coming in so that the final report will doubtless show an increase over the figures given.

A few main facts are being obtained regarding each institution including, in addition to the name and the address, the kind or classification, the auspices under which it is operated, how supported, the total number of patients and the total number of visits made in the last fiscal year, the class of people served, the educational functions, numbers of full-time and part-time physicians engaged, number of social workers and the kind of medical service rendered.

Several facts have been brought to light regarding outpatient departments and dispensaries. There is (1) a steady increase in the number of patients seeking treatment in general dispensaries; (2) an increasing tendency to charge nominal fees thereby placing part of the cost of the institution on the patients; (3) an increased use of social service workers to investigate the social and financial status and to prevent pauperizing; (4) the great amount of educational work; (5) the inadequacy of clinical and office record systems—hence the extreme difficulty of securing accurate data; (6) an unprecendented increase in special clinics and dispensaries such as those for tuberculosis, venereal diseases, mental hygiene and baby hygiene.

GROUP PRACTICE

Before beginning this survey so much had been heard about group practices that one was led to believe they were being rapidly developed which made them a matter of great concern to the profession. The impression of great growth and wide use of the group practice system, however, has not been sustained by the survey. In fact only 139 groups exist in the country at the present time even with the most liberal interpretation of the term, and less than 1,000 physicians are combined in them. For the sake of an understanding as to what group practice is, we may attempt to define it as the practice of medicine by an organization of physicians, in which (*a*) each member contributes to the group his professional service and receives from the group certain benefits in return; (*b*) the members unite in the diagnosis of cases that indicate need for their combined service. Under this definition it is believed we would not find in the country today one hundred group practices, including altogether possibly less than 700 physi-

cians. It is notable also that a large number of "group practices" are rather short-lived. At present, therefore, the group practice movement does not seem to warrant any very great concern on the part of the profession.

NUMBER OF HOSPITALS INCREASING

The number of hospitals has largely increased during the last fifteen years. In 1913, there were 2,424 general hospitals having twenty-five or more beds, and a total capacity of approximately 200,000 beds. In 1920, the number had increased to 4,012 with a total capacity of 307,356 beds. The latter figures did not include the 2,000 government hospitals, sanitariums for the insane, state sanitariums for the tuberculous, penitentiary hospitals, or homes for the aged, blind, incurables, etc. Also a number of disreputable hospitals were excluded.

The increasing number of hospitals is a direct response to the growing demand for hospital treatment by the public which is recognizing the improved methods of diagnosis and treatment in hospitals, as well as the freedom from noise, disturbances, and worry over household affairs so commonly experienced in home treatment. Through the instruction which they obtain in the examination and care of patients in hospitals; the familiarity which they obtain with the routine hospital methods of diagnosis and treatment, and the experience they obtain during the year devoted to the hospital internship, recent graduates realize the importance of having access to a hospital for the practice of modern medicine.

THE INCREASING DEMAND FOR INTERNS

Three factors in recent years have greatly increased the demand for interns: (*a*) The improved qualifications of the present-day graduates in medicine; (*b*) the rapidly increasing number of hospitals, and (*c*) the campaign to improve hospital service which has called for better records, including histories of patients, records of physical examinations, records of laboratory analyses, records showing the patients' progress and end results—work which rests largely on the intern. Ten years ago, many hospitals did not use interns and would not have them in the hospital and there were not enough internships available for those graduating each year. The improved qualifications of medical graduates, however, has led more hospitals to use intern service.

During the World War, instead of securing hospital internships, many graduates secured commissions in the government medical services. This created a demand for interns which since that time has become more and more pronounced. In 1918, 1,126 hospitals were seeking interns, these hospitals providing more internships than could be filled even in 1904 when this country had over half of the world's supply of medical schools.

The time has arrived, therefore, when the training of interns may with advantage be restricted to the hospitals having facilities and methods by which a fifth year of actual medical instruction can be furnished. Other hospitals will need to employ house physicians or to otherwise arrange for the services usually done by interns. The time has arrived also when state licensing boards should establish a general requirement of a hospital internship as an essential qualification for the license to practice. Nor will it be a hardship on the student if an intern training should hereafter be generally required by medical colleges as an essential for the M.D. degree. Such action by the medical schools would insure a more careful supervision of the intern's work as well as on the education furnished by the hospital.

SUMMARY

A summary of the foregoing report is as follows:

I. PROGRESS IN MEDICAL EDUCATION

1. In 1904 the United States had 162 medical colleges—more than were to be found in all the rest of the world. There was an overabundance of medical students and more graduates each year than the needs of the country warranted.

2. The campaign for improvement during the seventeen years, although it has reduced the numbers, respectively, of colleges, students and graduates, at the same time has remarkably improved the quality of each and the supply comes nearer to meeting the normal requirements of the country.

3. Where formerly educational standards of medical schools in the United States, with a few exceptions, were lower than in countries abroad, now the standards of medical education are at least equal to those found in any other country.

4. The lowest enrolment of medical students, resulting from the decrease in the number of colleges and the increased

entrance requirements, was reached in 1919 when there was a total of 13,052 medical students. A still lower ebb in the enrolment of individual classes began with the freshman class of 1919, resulting from the many enlistments for military service. As a result the class graduating in June will show the lowest number. Since 1919 the numbers of students matriculating each year have been remarkably on the increase.

II. NEW PROBLEMS IN MEDICAL EDUCATION

The higher entrance requirements, improved medical schools and the modern methods of teaching have created new problems in medical education. For example:

1. The necessity of limiting enrolments has made it difficult for well qualified students to secure enrolment in medical schools. It appears, however, that this difficulty is only temporary.

2. There is still ample room in Class A medical colleges for more than the total number of students enrolled in all colleges during the last session.

3. The cost of conducting medical schools under the present standards of medical education has been greatly increased. Instead of there being profits from students' fees, now the expense is from two to four times the amount obtained from students' fees. The average income reported by sixty-nine medical schools is $130,672, of which $35,135 (26.9 per cent.) was obtained from students' fees.

4. The average expenditure of each medical school was $123,947, including $46,162 (37 per cent.) for all-time teachers, and $21,131 (17 per cent.) for part-time teachers, which makes 54 per cent. for instruction. The average annual fee paid by the student was $185 and the average expense for his instruction was $655. In 1916 the average fee was $150 and the average expenditure was $419.

5. Certain dangers from specialization have developed in that (*a*) medical schools are turning out specialists rather than thoroughly trained general practitioners, and (*b*) graduates are inclined to pose as specialists without first securing the essential experience or special training. The situation requires a reorganization of the undergraduate curriculum and the requirement, eventually, of evidence of special training before the physician is entitled to pose as a specialist.

6. Since the World War the lack of physicians in the smaller towns and rural communities has become more acute.

It is evident that the solution of the problem is the establishing of hospitals in every center having sufficient population in the surrounding community to support a hospital.

7. A plan for the reorganization of the undergraduate curriculum calls for (*a*) the leaving of instruction in the specialties for the graduate school, (*b*) a less rigid division of the hours devoted to teaching in the various departments of the medical school, and (*c*) a closer correlation of clinical work with that of the so-called laboratory courses of instruction.

8. Among the acute problems of medical licensure are: (*a*) The licensing of graduates of low grade medical colleges by separate sectarian boards in Arkansas and Connecticut. (*b*) The licensing of osteopaths as physicians in a few states, notably California, Colorado, Oklahoma, and Texas. (*c*) The granting of separate boards for certain groups of "drugless" healers under a misconception of what is meant by the term "the practice of medicine," and (d) the importance of one standard of educational qualifications to be insisted upon alike for every one who is to be authorized to treat the sick.

III. WORK WITH HOSPITALS

1. The work of the American Medical Association with hospitals began in 1904 with the publication of the American Medical Directory and with the establishing of the "ideal standard" of medical education, including a hospital internship.

2. Three complete surveys of hospitals began, respectively, in 1912, 1915 and 1918.

3. In 1919, following the conference on medical education, the American Conference on Hospital Service was established.

4. In 1920 the work of the Council was enlarged to include all the work of the Association in connection with hospitals.

5. The first Hospital Number of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION was published April 16, 1921.

6. The number of general hospitals has increased from 2,440 in 1913 to 4,012 in 1920 and the total number of beds from 200,000 to 307,356. These figures do not include those in government hospitals, sanitariums for the tuberculous and the insane, penitentiary hospitals, homes for the aged, etc.

7. There is an increasing demand for interns, due mainly to the rapidly increasing number of hospitals, but also to the fact that a larger proportion of hospitals than formerly

is making use of intern service, this doubtless, in turn, being due to the better qualifications of medical graduates.

8. The Council is now conducting an extensive survey of outpatient departments of hospitals, general dispensaries, group practices and clinics for tuberculosis, venereal diseases, mental hygiene clinics, health centers, baby welfare clinics, etc., or, in brief, of all institutions that give medical service to ambulatory patients.

9. The survey shows already that there are 1,150 outpatient departments, 800 independent dispensaries, and approximately 200 clinics conducting what is properly referred to as "group practice." Including all clinics having to do with ambulatory patients, there are approximately 4,500. Complete returns will doubtless increase the figures given.

CONCLUSION

From the foregoing report, it will be seen that great progress has been made since the beginning of the Council's work in the elevation of standards of medical education and the improvement in quality of physicians entering practice. It is apparent, however, that instead of being diminished, the Council has a still larger function to perform in dealing with the newer problems and in doing what it can to bring the benefits of scientific medicine within the reach of the people of every community.

Respectfully submitted,

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS.

ARTHUR D. BEVAN, Chairman,
WILLIAM PEPPER,
MERRITTE W. IRELAND.
RAY LYMAN WILBUR,
SAMUEL W. WELCH,
N. P. COLWELL, Secretary.

Report of the Council on Scientific Assembly

To the Members of the House of Delegates of the American Medical Association:

On January 14 the Council held a conference with the secretaries of the sections of the Scientific Assembly at the headquarters of the Association. All the section secretaries were present with the following exceptions: The Section on Ophthalmology, which section was, however, represented by its chairman; the Section on Preventive Medicine and Public Health; the Section on Urology, and the Section on Gastro-Enterology and Proctology. All the members of the Council were in attendance with the exception of the President of the Association, Dr. Hubert Work, who was prevented from attending the meeting because of a serious injury to one of his principal associates.

The assignments for the meeting hours of the different sections for the 1922 annual session were announced as follows:

Sections to convene at nine o'clock in the mornings of Wednesday, Thursday and Friday, May 24, 25 and 26: Surgery, General and Abdominal; Ophthalmology; Diseases of Children; Pharmacology and Therapeutics; Nervous and Mental Diseases; Dermatology and Syphilology, and Preventive Medicine and Public Health; also one meeting of the Section on Miscellaneous Topics to present a program on Anesthesia to meet Wednesday morning, May 24.

Sections to convene at two o'clock in the afternoons of Wednesday, Thursday and Friday, May 24, 25 and 26: Practice of Medicine; Obstetrics, Gynecology and Abdominal Surgery; Laryngology, Otology and Rhinology; Stomatology; Pathology and Physiology; Urology; Orthopedic Surgery, and Gastro-Enterology and Proctology.

The Council assigned one of the meetings of the Section on Miscellaneous Topics for the 1922 Annual Session for the presentation of a program on anesthesia and appointed as officers for that meeting: Chairman, Dr. Isabella C. Herb, Chicago; Vice-Chairman, Dr. David E. Hoag, Pueblo, Colorado, and Secretary, Dr. F. H. McMechan, Avon Lake, Ohio.

NEW SECTIONS

The Council on Scientific Assembly has given careful consideration to the division of the Scientific Assembly into sections. The Council is of the opinion that no radical changes

should be made in the sections as they are now constituted. It holds that the principle which should be followed in any changes in the sections should be one which has for its object the coordinating of the work of the present sections and combining these rather than the establishment of additional sections. There are four outstanding reasons which justify the Council in urging that additional sections shall not be established: First, it is expedient that in the sections now established an opportunity should be afforded to present the new work that has been done in the field particularly assigned to the sections, as well as in fields closely allied thereto. For example, papers on anesthesia should be presented in the various sections rather than in a special section. The Section on Surgery undoubtedly would find much interest in the various anesthetics and in the technic of their administration. The pharmacologic and therapeutic questions relating to anesthesia are proper subjects for presentation in the Section on Pharmacology and Therapeutics.

Second, the Scientific Assembly should be reduced to just as few sections as possible rather than increased by the establishment of new sections, especially when it is impossible to define a field for the new section without interference with fields assigned to already existing sections.

Third, the multiplicity of sections would be practically unlimited if it is understood that a section is to be established for each field in medicine as these fields are defined by physicians who practice the several specialties. It is conceivable that requests will be received for sections on physical therapeutics, on hydrotherapy, on anesthesia, on roentgen ray work, on radium, and the list could be greatly extended. Every one of these specialties may logically claim a section in the Scientific Assembly unless the policy recommended by the Council on Scientific Assembly be approved by the House of Delegates, which is that the present established sections shall be encouraged—in so far as it is practical so to do—to provide in their programs for the presentation of papers setting forth the work of the more limited specialties, and that applications for new sections shall be considered in accordance with that principle.

Fourth, the Section on Miscellaneous Topics provides opportunity, in one, two or three meetings at any annual session, for the presentation of programs on subjects which do not fall within the scope of the other established sections. This section gives every advantage of audience and publication that the other sections afford.

Since the Boston meeting of the House of Delegates, no formal petitions for the establishment of new sections have come before the Council.

The Council again calls attention to the marked improvement in the Scientific Assembly which has resulted from the holding of but one meeting a day by each of the sections. This change was initiated by the Council on Scientific Assembly and through the cooperation of the officers of the sections was put in practice at the Annual Session in 1919. It makes it possible for the Fellow who is particularly interested in the work of a particular section to attend meetings of sections other than the one devoted to the specialty in which he has a personal interest, to visit the exhibits and in other ways to receive added benefits from the Annual Sessions of the Scientific Assembly. The plan has received the universal approval of the officers of the sections as well as of the Fellows in general.

CHANGE OF TITLE OF A SECTION

At the Boston Annual Session of the House of Delegates, the Section on Preventive Medicine and Public Health transmitted to the House of Delegates a formal request that the name of that section be changed to the Section on Preventive and Industrial Medicine and Public Health. The House of Delegates in turn referred this action to the Council. After giving the matter careful consideration, the Council recommends to the House of Delegates that the By-Laws of the Association be modified so as to provide that the title of the section in question shall be the Section on Preventive and Industrial Medicine and Public Health.

THE THERAPEUTIC VALUE OF ALCOHOL

The preambles and resolutions submitted to the House of Delegates from the Council on Health and Public Instruction and which pertained to the question of the therapeutic value of alcohol were referred to the Council on Scientific Assembly. The preambles and resolutions so referred were made the subject of a general discussion by the members of the Council, after which the Council on motion duly seconded and carried approved the following declaration; namely, that the subjects discussed in the preamble and resolutions involved scientific problems which have for a long period of time been the subjects of study by competent scientific investigators; that notwithstanding these investigations, there is no definite, generally accepted conclusion on these questions. The Coun-

cil deems it unwise to attempt to determine moot, scientific questions by resolution or by vote and recommends that, under the conditions cited, the House of Delegates shall take no action at this time on the question of the therapeutic value of alcohol. In making this recommendation, the Council calls attention to the fact that it has not taken under consideration nor does its recommendations apply to any of the social, economic or moral issues which are involved in or allied to the scientific problem presented—the determination of the therapeutic value of alcohol.

THE CONFERENCE OF SECTION SECRETARIES

One of the most effective measures in coordinating the work of the several sections which the Council has been putting into effect is the holding of the annual conference with the secretaries of the sections. The Council recommends that the House of Delegates approve the holding of this annual conference and that the House request the Board of Trustees, in formulating the annual budget of the Association, to make provision for holding this conference annually.

Respectfully submitted.

J. SHELTON HORSLEY, Chairman.
E. S. JUDD.
ROGER S. MORRIS.
F. P. GENGENBACH.
JOHN E. LANE.

Ex-officio.

GEORGE E. DE SCHWEINITZ,
President-Elect.
GEORGE H. SIMMONS,
Editor and General Manager.
ALEXANDER R. CRAIG, Secretary.

Constitution and By-Laws

OF THE

American Medical Association

REVISION OF 1921
AND
STANDING RULES

Constitution and By-Laws of the American Medical Association

1921

Constitution

Article 1.—Title and Definition

The name of this corporation is the American Medical Association; it is a federacy * of its constituent associations.

Article 2.—Objects

The objects of the Association are to promote the science and art of medicine and the betterment of public health.

Article 3.—Constituent Associations

Constituent associations are those state and territorial medical associations which are, or which may hereafter be, federated to form the American Medical Association, in accordance with this Constitution and By-Laws.

[**Federacy: A federation or union of several states under one central authority, consisting of delegates from each state in matters of general polity but self-governing in local matters. American Dictionary and Cyclopedia.*]

ARTICLE 4.—COMPONENT SOCIETIES

Component societies are those county or district medical societies contained within the territory of and chartered by the respective constituent associations.

ARTICLE 5.—HOUSE OF DELEGATES

SECTION 1.—The legislative powers of the association reside in the House of Delegates. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws, and shall elect the general officers.

SEC. 2.—COMPOSITION.—The House of Delegates is composed of delegates elected by the constituent associations and by the Sections of the Scientific Assembly, and of delegates from the Medical Departments of the Army and the Navy and the Public Health Service, appointed by the Surgeon-General of the respective departments. The Trustees shall be ex-officio members of the House of Delegates, but without the right to vote.

SEC. 3.—The total voting membership of the House of Delegates shall not exceed 150. The medical departments of the Army and of the Navy, and the United States Public Health Service and the scientific sections shall each be entitled to one delegate, and the remainder shall be apportioned among the Constituent Associations in proportion to their actual active membership as hereinafter provided in the By-Laws.

ARTICLE 6.—GENERAL OFFICERS

SECTION 1.—The general officers of the Association shall be a President, a Vice President, a Secretary, a Treasurer, a Speaker and a Vice Speaker of the House of Delegates, and nine Trustees.

SEC. 2.—These officers shall be elected annually and shall serve for one year, except the Trustees, three of whom shall be elected annually, each to serve three years, or until their successors are elected and installed.

ARTICLE 7.—TRUSTEES

The Board of Trustees shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations.

ARTICLE 8.—MEMBERS AND FELLOWS

SECTION 1.—MEMBERS OF THE AMERICAN MEDICAL ASSOCIATION.—Members in good standing of the constituent associations are the members of the American Medical Association, subject, however, to the provisions of these By-Laws regarding members.

SEC. 2.—FELLOWS OF THE SCIENTIFIC ASSEMBLY.—Members in good standing of the Association who have complied with the provisions of the By-Laws regarding Fellows, are Fellows of the Scientific Assembly of the American Medical Association.

ARTICLE 9.—SCIENTIFIC ASSEMBLY

SECTION 1.—The Scientific Assembly of the American Medical Association is the convocation of its Fellows for the presentation and discussion of subjects pertaining to the science and art of medicine.

SEC. 2.—The Scientific Assembly is divided into sections, each section representing that branch of medicine described in its title.

SEC. 3.—New sections may be created or existing sections discontinued by the House of Delegates. The Scientific Assembly and its sections shall be conducted in accordance with the rules and regulations set forth in this Constitution and By-Laws.

ARTICLE 10.—ANNUAL SESSIONS

The House of Delegates and the Scientific Assembly shall meet annually at times and places to be fixed by the House of Delegates. The time and place of any of these sessions may, however, be changed by the unanimous action of the Board of Trustees at any time prior to two months of the time selected for that session. A session may be held at any place in the United States.

ARTICLE 11.—FUNDS

Funds may be raised by an equal assessment of not more than ten dollars annually on each of the members; from the Association's publications, and in any other manner approved by the Board of Trustees. Funds may be appropriated by the Board of Trustees to defray the expenses of the Association; to carry on its publications; to encourage scientific investigations and for any other purpose approved by the Board of Trustees.

ARTICLE 12.—AMENDMENTS

The House of Delegates may amend this Constitution at any annual session, provided the proposed amendment shall have been introduced at the pre-

ceding annual session, and provided three fourths of the voting members of the House of Delegates registered at the session at which action is taken vote in favor of such change or amendment.

By-Laws

BUSINESS AND LEGISLATION

CHAPTER I.—QUALIFICATIONS, TERM, APPORTIONMENT AND REGISTRATION OF DELEGATES

SECTION 1. DELEGATES MUST HAVE BEEN FELLOWS OF THE AMERICAN MEDICAL ASSOCIATION TWO YEARS. —A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.

SEC. 2. TERM.—Delegates and alternates from constituent associations shall be elected for two years. Constituent associations entitled to more than one representative shall elect them so that one-half, as near as may be, shall be elected each year. Delegates and alternates elected by the sections, or delegates appointed from the United States Army, United States Navy and United States Public Health Service shall hold office for one year.

SEC. 3. APPORTIONMENT OF DELEGATES. — At the annual session of 1903, and every third year thereafter, the House of Delegates shall appoint a committee of five on reapportionment, of which the Speaker and the Secretary shall be members. The committee shall apportion the delegates among the constituent associations in accordance with Article 5, Section 3, of the Constitution, and in proportion to the membership of each constituent association as recorded in the office of the Secretary of the American Medical Association on April 1 of the year

in which the apportionment is made. This apportionment shall take effect at the next succeeding annual session, and shall prevail until the next triennial apportionment, whether the membership of the constituent association shall increase or decrease.

SEC. 4. REGISTRATION OF DELEGATES.—Each delegate representing a constituent association, before being seated, shall deposit with the committee on credentials a certificate signed by the Secretary and under the seal of the constituent association stating that he has been regularly elected a delegate by that constituent association. Each delegate from a section shall present similar credentials signed by the chairman and the secretary of the section which he represents. Each delegate from a government service shall present credentials stating he has been duly appointed by the Surgeon-General of the department which he represents.

SEC. 5. A DELEGATE, ONCE SEATED, TO RETAIN HIS SEAT FOR THE ENTIRE SESSION.—A delegate whose credentials have been accepted by the committee on credentials and whose name has been placed on the roll of the House, shall remain a delegate of the body which he represents until final adjournment of the session, and his place shall not be taken by any other delegate or alternate.

CHAPTER II.—PROCEDURE OF HOUSE OF DELEGATES

SECTION 1. ORDER OF BUSINESS. — The following shall be the order of business, unless otherwise ordered:

1. Call to order by the Speaker.
2. Roll call.

3. Reading and adopting the minutes.
4. Reports of officers.
5. Reports of committees.
6. Unfinished business.
7. New business.

SEC. 2. LIMIT OF TIME FOR INTRODUCTION OF NEW BUSINESS.—Unanimous consent shall be required for the introduction of new business at the last meeting of the annual session of the House of Delegates, except when presented by the Board of Trustees, the officers of the sections, or the sections. All new business so presented shall require three-fourths affirmative vote for adoption.

SEC. 3. RULES OF ORDER.—The House of Delegates shall be governed by Robert's Rules of Order when not in conflict with these By-Laws or with the rules of the House.

SEC. 4.—QUORUM.—Twenty voting members of the House of Delegates shall constitute a quorum.

CHAPTER III.—MEETINGS OF THE HOUSE OF DELEGATES

SECTION 1. REGULAR SESSIONS.—The House of Delegates shall meet annually on the Monday preceding the opening of, and at the same place as, the Scientific Assembly of the Association.

SEC. 2.—SPECIAL SESSIONS.—Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty-seven or more delegates, representing a majority of the constituent associations. When a special session is thus called, the Secretary shall mail a notice to the last known address of each member of the last House of Delegates at least twenty days before such special session

is to be held, in which notice shall be specified the time and place of meeting and the items of business to be considered. No other business shall be transacted at the special session than that specified in the call.

CHAPTER IV.—NOMINATION AND ELECTION OF OFFICERS, ASSOCIATE AND HONORARY FELLOWS. INSTALLATION OF OFFICERS

SECTION 1. NOMINATIONS.—Nominations for office shall be made orally, but a nominating speech must not exceed two minutes. The Treasurer shall be nominated by the Board of Trustees. No member of the House of Delegates nor general officer of the Association shall be eligible to the office of President or Vice President.

SEC. 2. QUALIFICATIONS OF GENERAL OFFICERS.—The General Officers must have been members of the Association and Fellows of the Scientific Assembly for at least two years next preceding their election. The Speaker and Vice Speaker of the House may but need not be elected from among the members of the House.

SEC. 3. METHOD OF HOLDING ELECTIONS.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. However, when there is only one nominee for an office, a majority vote without ballot shall elect.

SEC. 4. TIME OF ELECTION.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the afternoon of the fourth day of the Annual Session of the House of Delegates (Thursday), provided, however, that the House of Delegates may change the time of election by action taken at least one day in advance of that to which the election is to be changed, and provided further that the motion to change the time of election shall be supported by two-thirds of the delegates registered.

The election of Affiliate, Associate and Honorary Fellows shall immediately follow the election of officers. Not more than three Honorary Fellows shall be elected at any annual session except on special recommendation of the Council on Scientific Assembly and the unanimous vote of the House.

SEC. 5. ASSOCIATE FELLOWS. — Applications for Associate Fellowship from foreign physicians must be approved by the Judicial Council; applications from dentists must be approved by the Section on Stomatology, from pharmacists by the Section on Pharmacology and Therapeutics, and from representative teachers and students of science allied to medicine by the officers of a section.

SEC. 6. AFFILIATE AND HONORARY FELLOWS. — Nominations for Affiliate Fellowship shall be made by the constituent association of which the nominee is a member, and nominations for Honorary Fellowship shall be made by the sections, and must be submitted to the House of Delegates not later than the second day of the Scientific Assembly.

These nominations shall be referred without debate to the Council on Scientific Assembly, which shall consider the scientific attainments and professional character of the applicants and report to the House of Delegates.

SEC. 7. INSTALLATION.—The general officers of the Association, except the President, shall assume their duties at the close of the last meeting of the annual session at which they are elected.

SEC. 8. INSTALLATION OF THE PRESIDENT.—The President shall be installed at the opening general meeting of the Scientific Assembly of the annual session following that at which he was elected.

CHAPTER V.—DUTIES OF OFFICERS

SECTION 1. PRESIDENT.—The President shall preside at the general meetings of the Scientific Assembly. At the opening general meeting of the Scientific Assembly next following his election he shall deliver an address on such matters as he may deem of importance to the public and to the medical profession. He may attend the meetings of and make suggestions to the House of Delegates or the Board of Trustees. With the approval of the Board of Trustees he is authorized to appoint committees for emergencies not otherwise provided for. He shall nominate members of standing committees for election by the House of Delegates.

SEC. 2. VICE PRESIDENT.—The Vice President shall officiate for the President during the latter's absence, or at his request. In case of death, resignation or removal of the President, the Vice President shall officiate during the unexpired term.

SEC. 3. SPEAKER.—The Speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require. He shall have the right to vote only when his vote shall be the deciding vote.

SEC. 4. VICE SPEAKER.—The Vice Speaker shall officiate for the Speaker in the latter's absence or at his request. In case of death, resignation, or removal of the Speaker, the Vice Speaker shall officiate during the unexpired term.

SEC. 5. SECRETARY.—The Secretary, in addition to the duties ordinarily devolving on the secretary of a corporation and those delegated in other sections of these By-Laws, shall give due notice of the time and place of annual and special sessions of the House of Delegates and of the Scientific Assembly in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. He shall send an official notice of each annual or special session to the secretary of each constituent association and to the secretary of each section. He shall keep the minutes of the House of Delegates. He shall notify members of committees of their appointment and of the duties assigned them. He shall verify the credentials of the members of the House of Delegates and shall provide a registration book in which shall be recorded the name of each delegate in attendance at each session, together with that of the constituent association, government service or section which he represents. He shall prepare for publication the official programs for the Scientific Assembly, and shall perform such other duties as may be directed by the House of Delegates, or the Board of Trustees.

SEC. 6. TREASURER.—The Treasurer shall be the custodian of all moneys, securities and deeds belonging to the Association which may come into his possession, and shall hold the same subject to the direction and disposition of the Board of Trustees. He shall give to the Board of Trustees a suitable bond for the faithful performance of his trust, and shall receive for his service a salary to be fixed by the Board of Trustees.

SEC. 7. OFFICERS TO COMPLETE BUSINESS OF SESSION.—All business of each annual session shall be completed by the officers (including section officers) who have served during the session.

CHAPTER VI.—BOARD OF TRUSTEES

SECTION 1. BOARD OF TRUSTEES.—The Trustees at their first meeting after the annual session of the House of Delegates, shall organize by electing a chairman and a secretary, and the chairman shall appoint such committees as may be created by the Board. It shall be the duty of this Board to provide for and to superintend the publication of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, and of all proceedings, transactions and memoirs of the Association. It shall have full discretionary power to omit from THE JOURNAL, in part or in whole, any paper that may be referred to it by any of the sections. It shall appoint a general manager and an editor of THE JOURNAL, which two positions may be held by one person, and such assistants as may be necessary, and shall determine their salaries and the terms and conditions of their employment. All resolutions or recommendations of the House of Delegates pertaining

to the expenditure of money must be approved by the Board of Trustees before the same shall become effective. During the annual session of the Association the Board shall hold meetings as often as may be deemed necessary by the chairman, and all matters referred to it by the House of Delegates shall be reported on within twenty-four hours, if so requested by the House. The Board of Trustees shall have the accounts of the Treasurer and of THE JOURNAL office audited annually or oftener, if deemed necessary, and shall make an annual report to the House of Delegates, which report among other items shall specify the character and cost of all the publications of the Association during the year and the amount of all property belonging to the Association. Should a vacancy occur, on account of death or otherwise, among the general officers of the Association, the Board of Trustees may fill such vacancy until the next annual session of the House, unless otherwise provided for in this Constitution and By-Laws. The Board of Trustees shall fix the salary of the Secretary and of the Treasurer. Regular meetings of the Board shall be held immediately after the annual session of the House of Delegates, and on the first Friday in the month of February of each year. Special meetings of the Board may be called at any time by the chairman, or by five members of the Board, by mailing a written or printed notice to the last known address of each trustee, at least five days before such meeting is to be held, in which notice shall be specified, in general terms, the object of such special meeting, and no other business shall be transacted thereat; provided, that the proceedings of any meeting of the

Board at which all the members are present or which are approved in writing by every member of the Board shall be valid without previous notice having been given. Five members of the Board shall constitute a quorum. During the intervals between the sessions of the House of Delegates the Board of Trustees shall supervise the action of committees constituted by the action of the House and may appoint emergency committees.

SEC. 2. TRUSTEES TO CONTROL SESSION. — The Board of Trustees shall have full control of all arrangements for the annual sessions and shall provide meeting places for the House of Delegates, the general meetings and the scientific sections. It shall also have control of all exhibits. It may appoint a local committee of arrangements, which shall be at all times under the Board.

CHAPTER VII.—COMMITTEES

SECTION 1. CLASSIFICATION OF COMMITTEES. — Committees shall be classified as (*a*) Standing Committees, (*b*) Reference Committees, and (*c*) Special Committees. The standing committees shall be nominated by the President and elected by the House of Delegates, unless otherwise provided for. Reference and special committees shall be appointed by the Speaker as provided in these By-Laws. Special committees may be created by the House of Delegates to perform the special functions for which they are created; they shall be appointed by the Speaker unless otherwise ordered by the House. Committees acting during the interval between the sessions of the House of Delegates shall be subject to the Board of Trustees. In case of vacancies in committees

occurring during the interval between annual sessions, the President or the Speaker, according to the committee on which said vacancies occur, shall have the power to appoint Fellows to fill the vacancies until the next annual session.

SEC. 2. MEMBERSHIP OF COMMITTEES.—Any Fellow shall be eligible to serve on standing or special committees. Reference committees shall be appointed from the members of the House of Delegates. Members of committees not members of the House of Delegates shall have the right to present their reports in person to the House and to participate in the debate thereon, but shall not have the right to vote. The House of Delegates may recall the election of any officer or the appointment of any member of a committee or Council at any session by a two-thirds vote of the members of the House of Delegates present and voting, provided that no motion for recall shall be acted on till the day following that on which it is introduced.

SEC. 3. STANDING COMMITTEES. — Standing committees shall be the following:

(*a*) Judicial Council.
(*b*) Council on Health and Public Instruction.
(*c*) Council on Medical Education and Hospitals.
(*d*) Council on Scientific Assembly.

CHAPTER VIII.—ORGANIZATION OF STANDING COMMITTEES OR COUNCILS

SECTION 1. MEMBERSHIP.—The Standing Committees, or Councils, shall consist of five members, each elected for five years. The term of office of the members of each committee shall terminate in succession,

one each year, and the House of Delegates shall elect annually, on nomination by the President, one member to each committee to fill the vacancy. The members of the Council on Scientific Assembly shall be chosen, as far as practical, from ex-section officers representing different sections, the President-Elect, the Secretary of the Association and the Editor of THE JOURNAL shall be ex-officio members of this Council.

SEC. 2. OFFICERS.—The Councils shall organize and elect their own officers except that the Secretary of the Association shall be the Secretary of the Judicial Council, and of the Council on Scientific Assembly and that on nomination by the respective Council, the Board of Trustees shall elect annually, to serve one year, a secretary of the Council on Health and Public Instruction and of the Council on Medical Education and Hospitals, and shall fix the salary of each.

SEC. 3. EXPENDITURES.—Each Council shall submit to the Board of Trustees a budget of its expenses for the fiscal year, and the Board shall make such appropriation for each Council as it may see fit. Each Council shall be limited in its expenditures to the appropriation made for it by the Board of Trustees and no Council shall expend or contract to expend any money in excess of its appropriation without the consent and approval in writing of the Board of Trustees.

SEC. 4. RULES AND REGULATIONS.—Each Council may make its own rules to govern its action; such rules shall not conflict with these By-Laws nor with standing rules or resolutions of the House of Delegates.

SEC. 5. COMMITTEES.—Each Council shall have authority to appoint committees subject to the approval of the Board of Trustees for any purpose within the jurisdiction of the Council.

SEC. 6. HEADQUARTERS.—The headquarters of each Council shall be at the general office of the Association where the transactions of the Council shall be recorded.

SEC. 7. REPORTS.—Each Council shall submit annually a report of its work to the House of Delegates. All such reports, so far as possible, shall be transmitted thirty days before the annual session to the Secretary of the Association, who shall have them printed for distribution to the members of the House of Delegates.

CHAPTER IX.—DUTIES OF STANDING COMMITTEES OR COUNCILS

SECTION 1. THE JUDICIAL COUNCIL.—The judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final. This power shall extend to and include (1) all controversies arising under this Constitution and By-Laws to which the American Medical Association is a party; and (2) controversies (*a*) between two or more recognized constituent associations, (*b*) between a constituent association and a component society or societies of another constituent association or associations or a member or members of another constituent association or other constituent association, and (*c*) between members of different constituent associations. In all these cases the Judicial Council shall have original jurisdiction.

In all cases which arise (a) between a constituent association and one or more of its component societies; (b) between component societies of the same constituent association; (c) between a member or members and the component society to which said member or members belong, or (d) between members of different component societies of the same constituent association, the Judicial Council shall have appellate jurisdiction in questions of law and procedure but not of fact.

The Judicial Council may, at its discretion, investigate general professional conditions and all matters pertaining to the relations of physicians to one another and to the public, and may make such recommendations to the House of Delegates or the constituent associations as it deems necessary.

SEC. 2. COUNCIL ON HEALTH AND PUBLIC INSTRUCTION.—The functions of the Council on Health and Public Instruction shall embrace the following subjects: (1) Legislation. (2) Public Instruction. (3) Defense of Medical Research. (4) Public Health.

SEC. 3. COUNCIL ON MEDICAL EUCATION AND HOSPITALS.—The functions of the Council on Medical Education and Hospitals shall be: (1) To investigate conditions of Medical Education, Hospitals and associated subjects and to suggest means and methods by which the same may be improved. (2) To endeavor to further the realization of such suggestions as may be approved by the House of Delegates.

SEC. 4. COUNCIL ON SCIENTIFIC ASSEMBLY.—The function of the Council on Scientific Assembly shall be: (1) To secure cooperation between the sections

proposed amendments to the Constitution and By-Laws. (The members of the Judicial Council shall be members, *ex officio,* of this committee.)

(7) A Committee on Reports of Officers, to which shall be referred the address of the President and of the Speaker of the House of Delegates and the reports of the Secretary and of the Board of Trustees.

(8) A Committee on Credentials, to which shall be referred all questions regarding the registration and the credentials of delegates.

(9) A Committee on Miscellaneous Business, to which shall be referred all business not otherwise disposed of.

of each meeting, or during the meeting, if necessary. take up and consider such business as may have been referred to it, and shall report on the same at the next meeting or when called on to do so. Three members shall constitute a quorum.

SEC. 4. COMMITTEES.—The following committees are hereby provided:

(1) A Committee on Sections and Section Work, to which shall be referred all matters relating to the sections and the section work. (The members of the Council on Scientific Assembly shall be members, *ex officio,* of this committee.)

(2) A Committee on Rules and Order of Business, to which shall be referred all matters regarding rules governing the action, methods of procedure and order of business of the House of Delegates.

(3) A Committee on Medical Education, to which shall be referred all matters relating to medical colleges and medical education. (The members of the Council on Medical Education and Hospitals shall be members, *ex officio,* of this committee.

(4) A Committee on Legislation and Public Relations to which shall be referred all matters relating to state and national legislation memorials to Legislatures, to the United States Congress, or to the President of the United States. (The members of the Council on Health and Public Instruction shall be members, *ex officio,* of this committee.)

(5) A Committee on Hygiene and Public Health, to which shall be referred all matters relating to hygiene and public health.

(6) A Committee on Amendments to the Constitution and By-Laws, to which shall be referred all

proposed amendments to the Constitution and By-Laws. (The members of the Judicial Council shall be members, *ex officio*, of this committee.)

(7) A Committee on Reports of Officers, to which shall be referred the address of the President and of the Speaker of the House of Delegates and the reports of the Secretary and of the Board of Trustees.

(8) A Committee on Credentials, to which shall be referred all questions regarding the registration and the credentials of delegates.

(9) A Committee on Miscellaneous Business, to which shall be referred all business not otherwise disposed of.

Scientific Assembly

MEMBERSHIP AND FELLOWSHIP

CHAPTER XI.—MEMBERSHIP AND FELLOWSHIP

SECTION 1. TENURE OF MEMBERSHIP.—Membership in this Association shall continue only so long as the individual is a member of a constituent association. When the Secretary shall be officially informed by the secretary of the constituent association through which a member holds membership in this Association that the member is not in good standing, the Secretary shall remove the name of said member from the membership roll of the American Medical Association. A member of a constituent association who removes to and engages in the practice of medicine at a location in another state in which there is a constituent association, shall forfeit his membership in this Association and the Secretary shall remove his name from the roster of members of the American Medical Association unless within one year after such change of residence he become a member of the constituent association in the state to which he has moved; provided that when the member is also a Fellow of the Scientific Assembly the By-Law defining the effect on Fellowship of removal to another state shall have precedence over this section.

SEC. 2. FELLOWS.—Any member of this Association, who on the prescribed form shall apply for

Fellowship and subscribe for THE JOURNAL, paying the annual Fellowship dues for the current year, shall be a Fellow.

Commissioned medical officers of the United States Army, United States Navy and the United States Public Health Service shall be Fellows of this Association so long as they are engaged actively in their respective service, and thereafter if they have been retired on account of age or physical disability. These Fellows shall not be required to pay Fellowship dues and shall not receive THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION except by personal subscription.

SEC. 3. EFFECT ON FELLOWSHIP OF REMOVAL TO ANOTHER STATE.—A Fellow who changes the location at which he practices medicine, from the state through whose constituent association he holds membership in the American Medical Association to another state in which there is a constituent association, is eligible to membership in the component society of his new location on the presentation of a transfer card and an official statement that his dues have been paid in full in the society in which he holds membership. He shall forfeit his Fellowship in the American Medical Association one year after such change of location, unless he becomes a member of the constituent association of the state to which he has moved. Provided, however, that if the component society into whose territory such Fellow has moved shall refuse him membership, the Fellow shall be privileged to appeal to the Judicial Council of this Association to determine whether or not he be guilty of any act that warrants the enforcement of the

provisions of this section. Pending the decision of such appeal he shall retain his Fellowship in the American Medical Association through his original state association. A member of a constituent state association who is located for the purpose of practicing medicine in a state adjacent to that through the association of which he holds Fellowship in the American Medical Association may become and may be continued a Fellow of the American Medical Association, provided the Council of the constituent association of the state in which he is practicing medicine waives jurisdiction over his membership.

SEC. 4. AFFILIATE, ASSOCIATE AND HONORARY FELLOWS.—There shall be Affiliate, Associate and Honorary Fellows, who shall be elected and shall qualify in accordance with the provisions set forth in these By-Laws.

SEC. 5. AFFILIATE FELLOWS. — A Fellow who has been a Fellow for a continuous term of fifteen (15) years, who is not less than sixty-five (65) years of age, and who is an honorary member of his component society and of his constituent association, or is connected with these organizations in an equivalent manner whereby he is relieved from the payment of dues or fees, on request of his constituent association may be made an Affiliate Fellow by a majority vote of the House of Delegates of this Association. Affiliate Fellows shall be privileged to participate in the Scientific Assembly of the Association; they shall not be required to pay Fellowship dues and shall not receive THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION except by personal subscription. Affiliate Fellowship shall be conditioned on such an

Affiliate Fellow continuing the relationship with his constituent association herein defined.

SEC. 6. ASSOCIATE FELLOWS.—The following may be elected in accordance with Section 5, Chapter IV, to Associate Fellowship: Physicians who are members of the chartered national medical societies of foreign countries adjacent to the United States; dentists holding the degree of D.D.S. who are members of state or local dental societies, and pharmacists who are active members of the American Pharmaceutical Association; and representative teachers, students of science allied to medicine, resident in the United States, and not eligible to regular membership. Associate Fellows shall enjoy the same privileges as regular Fellows, and shall be subject to the same conditions.

SEC. 7. HONORARY FELLOWS.—Physicians of foreign countries may be elected Honorary Fellows by the House of Delegates in accordance with Section 6, Chapter IV.

SEC. 8. INVITED GUESTS.—Scientists resident in the United States who are not engaged in the practice of medicine, and eminent physicians and scientists from foreign countries, may be invited by the general officers or by the officers of a section, to attend an annual session of the Scientific Assembly and participate in the scientific work and social functions. They shall be designated as Invited Guests.

SEC. 9. TENURE OF FELLOWSHIP.—Fellowship in this Association shall continue only so long as the individual is a member. When the Secretary shall be officially informed that the Fellow is not a member, the Secretary shall remove the name of such Fellow from the Fellowship roll of the American

Medical Association and shall notify the Fellow of the action taken, together with the reason therefor. Fellowship shall be further conditioned on a Fellow conducting himself in accordance with this Constitution and By-Laws, and Principles of Medical Ethics of this Association.

SEC. 10. DELINQUENCY.—Any Fellow who, for one year, has failed to pay his annual Fellowship dues, shall forfeit his Fellowship thirty days after notice of his delinquency has been mailed to his last known address by the Secretary.

SEC. 11. FELLOWSHIP RESTORED.—Any former Fellow who complies with Section 2, Chapter XI, shall be reinstated on payment of his indebtedness, including his subscription for the current calendar year.

CHAPTER XII.—REGISTRATION

Fellows, Affiliate, Associate and Honorary Fellows and Invited Guests only shall be allowed to register or take part in the work of any of the sections of the Scientific Assembly of the Association.

A Fellow shall be eligible to register at an annual session only after he has paid all of his current indebtedness.

A Fellow shall not be permitted to take part in the proceedings of the Association or of any of the sections until he has registered his name and address in the registration office.

A Fellow on registering shall designate the section in which he wishes to be enrolled, but shall be enrolled in one section only at any Scientific Assembly.

CHAPTER XIII.—GENERAL MEETINGS

SECTION 1. GENERAL MEETINGS.—General meetings of the Scientific Assembly may be arranged by the Council on Scientific Assembly with the approval of the Board of Trustees.

SEC. 2. THE OPENING GENERAL MEETING.—The opening general meeting shall be held on the evening of Tuesday of the week of the annual session, and shall be presided over by the President or, in his absence or at his request, by the Vice President.

SEC. 3. PRESIDENT'S ADDRESS.—The President, immediately after he is inducted into office, shall deliver an address before the opening general meeting, and his recommendations, if he makes any, shall go to the House of Delegates for action.

CHAPTER XIV.—SECTIONS

SECTION 1. TITLES OF SECTIONS OF SCIENTIFIC ASSEMBLY.—The Scientific Assembly of the American Medical Association shall be divided into the following sections:

1. Practice of Medicine.
2. Surgery, General and Abdominal.
3. Obstetrics, Gynecology and Abdominal Surgery.
4. Ophthalmology.
5. Laryngology, Otology and Rhinology.
6. Diseases of Children.
7. Pharmacology and Therapeutics.
8. Pathology and Physiology.
9. Stomatology.
10. Nervous and Mental Diseases.
11. Dermatology and Syphilology.

12. Preventive Medicine and Public Health.
13. Urology.
14. Orthopedic Surgery.
15. Gastro-Enterology and Proctology.
16. Miscellaneous Topics.

SEC. 2. OFFICERS OF SECTIONS.—The officers of each section shall consist of a chairman, a vice chairman and a secretary and such other officers as the section shall deem advisable. These shall serve for one year, or until their successors are elected and qualified; provided, that each section may elect its secretary to serve a longer time at its discretion. Each section shall also elect annually one delegate and one alternate to the House of Delegates of the American Medical Association to serve one year.

SEC. 3. ELECTION OF OFFICERS.—The election of officers of the several sections shall be the first order of business of the final meeting of the section at each Scientific Assembly. To participate in the election of any section a Fellow must have indicated on registering that he desires to affiliate with such section, and must have recorded his name and address on the section register book.

SEC. 4. DUTIES OF SECTION OFFICERS.—(*a*) Chairman.—The chairman shall preside at the meetings of the section and shall perform such duties as usually belong to such an office, or as may be provided by the by-laws of the section. He shall cooperate with the secretary in arranging the program, and shall see that proper arrangements are made for his section at the Scientific Assembly.

(*b*) Vice Chairman.—The vice chairman shall assist the chairman in the performance of his duties and shall preside in his absence, or at his request.

(*c*) Secretary.—The secretary shall keep a record of the proceedings of the section in a book provided for such purpose; shall, with the cooperation of the chairman, and in accordance with rules and regulations enacted by the House of Delegates, arrange the program; and shall, at least thirty days before the Scientific Assembly, forward it to the Secretary of the Association for insertion in the official program; and shall perform such other duties pertaining to his office as may be provided by the by-laws of the Association or of the section.

SEC. 5. EXECUTIVE COMMITTEE.—Each section shall have an executive committee, which shall consist of the chairman and the last two retiring chairmen. In case of absence of a member of the executive committee of a section from a Scientific Assembly, the vacancy shall be filled by the chairman of the section. This committee shall examine and pass on all papers read before the section, and shall endorse for publication only those that are of scientific or of practical value, and which will reflect credit on the section before which they were read. It shall act as the nominating committee of the section.

SEC. 6. MEETINGS.—Sections shall hold meetings at 9 a. m. and 2 p. m. daily in accordance with the program for the Scientific Assembly, as arranged by the Council on Scientific Assembly.

SEC. 7. WHO MAY TAKE PART IN SECTION WORK.—Fellows and Associate Fellows only shall have the right to participate in the business deliberations of

a section. Fellows, Affiliate, Associate, and Honorary Fellows, and Invited Guests may present papers and take part in the scientific discussions.

SEC. 8. ASSOCIATE FELLOWS.—The officers of a section may nominate for Associate Fellowship representative teachers and students of sciences allied to medicine, resident in the United States, not eligible to regular membership. The secretary shall immediately notify the Secretary of the Association of such nominations.

SEC. 9. HONORARY FELLOWS.—Each section at each Scientific Assembly may nominate for Honorary Fellowship in the American Medical Association a physician of a foreign country who has risen to preeminence in the profession of medicine; provided, however, that nominations for Honorary Fellowship in the American Medical Association shall be acted on by the sections on or before the second day of each Scientific Assembly. The secretary of the section shall immediately notify the Secretary of the Association of such nomination.

SEC. 10. TIME AT WHICH TITLES MUST BE IN.—Titles of papers to be presented to the section must be in the hands of the secretary of the section at least thirty-five days before the first day of the Scientific Assembly. With the title, the writer shall submit an abstract of the paper not less than thirty or more than one hundred and fifty words in length and an estimate of the time required to read his paper.

SEC. 11. LENGTH OF PAPERS AND DISCUSSIONS.—The time allowed for the presentation of a paper

before a section shall be limited to fifteen minutes. No one shall discuss any paper more than once, nor for longer than five minutes except with the unanimous consent of those present.

SEC. 12. NUMBER OF PAPERS ON PROGRAM.—The number of papers, including addresses, on the program of any section shall not exceed twenty-five.

SEC. 13. CAN PRESENT ONLY ONE PAPER AT AN ANNUAL SESSION.—A Fellow shall present no more than one paper at any Scientific Assembly.

SEC. 14. SECTION TO PROVIDE BY-LAWS.—Each section may make by-laws for its own government, provided that they shall in no way conflict with the Constitution and By-Laws of the American Medical Association.

CHAPTER XV.—PUBLICATION

SECTION 1. PAPERS APPROVED FOR PUBLICATION.—No paper shall be published as having been read before a section unless it has received the approval and the endorsement of each member of the executive committee of the section before which it was read.

SEC. 2. PAPERS MUST BE READY FOR PUBLICATION.—Each author shall hand his paper to the secretary of the section immediately after it is read. The secretary shall endorse thereon that it has been read and shall hand it to the chairman of the executive committee. All papers approved by the executive committee shall be returned to the secretary of the section, who shall at once forward them to the editor of THE JOURNAL.

SEC. 3. PAPERS "READ BY TITLE."—No paper shall be published as having been read before a section unless it has actually been read by its author, or unless, for special reasons, when the author has been present and prepared to read the paper, the section shall unanimously vote to have it read by title.

SEC. 4. PAPERS THE PROPERTY OF THE ASSOCIATION.—All papers and reports presented to a section and approved by the executive committee shall become the exclusive property of the Association, provided that the Board of Trustees may permit an author to publish his paper elsewhere than in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

MISCELLANEOUS

Chapter XVI.—Official Resolutions Approved by the House of Delegates

No memorial, resolution or opinion of any character whatever shall be issued in the name of the American Medical Association unless it has been approved by the House of Delegates.

Chapter XVII.—Annual Fellowship Dues

The annual Fellowship dues shall be six dollars, payable in advance on the first day of January of each year, of which not less than five dollars shall be credited to the subscription for one year to The Journal.

Chapter XVIII.—Articles of Incorporation

The House of Delegates, at any annual session, wherever the same may be held, may instruct the Board of Trustees to make any changes in the articles of incorporation in accordance with the law which may appear desirable, or which may be made necessary by any change or amendment to the Constitution and By-Laws of this Association.

Chapter XIX.—Amendment to These By-Laws

These By-Laws may be amended on a three fourths vote of the House of Delegates, provided that no amendment shall be acted on till the day following that on which it is introduced; except that the Board of Trustees may, by unanimous vote, make such changes, and such changes only, as may be required to adapt them to the rules and regulations of the United States postal authorities.

Index to Constitution and By-Laws

STANDING RULES
HOUSE OF DELEGATES
AMERICAN MEDICAL ASSOCIATION
1921

Papers for Publication

Adopted at Boston, June 8, 1865

"*Resolved,* That the several sections of this Association be requested, in the future, to refer no papers or reports to the Committee of Publication [the Board of Trustees], except such as can be fairly classed under one of the three following heads, viz.: 1. Such as may contain and establish positively new facts, modes of practice or principles of real value. 2. Such as may contain the results of well devised original experimental researches. 3. Such as present so complete a review of the facts on any particular subject as to enable the writer to deduce therefrom legitimate conclusions of importance."

Solicitation of Votes

Adopted by the House of Delegates at Saratoga Springs, N. Y., June 13, 1902

"*Resolved,* That it is the sense of the House of Delegates of the American Medical Association that the solicitation of votes for office is not in keeping with the dignity of the medical profession, nor in harmony with the spirit of this Association, and that

such solicitation shall be considered a disqualification for election to any office in the gift of the Association."

REPORTS, RESOLUTIONS, ETC.

Adopted by the House of Delegates at Boston, June 7, 1906

"*Resolved*, That in future all reports, resolutions, amendments to the Constitution and By-Laws, etc., be furnished in duplicate, one copy to be furnished the Secretary for the official minutes and the other to committeemen; and that the Secretary be instructed to engage a typewritist for the use of committeemen in making their reports."

PENSIONS OR ANNUITIES

Adopted by the House of Delegates at Atlantic City, N. J., June 9, 1909

"*Resolved*, That no proposition or resolution advocating the payment of a pension or annuity to any member or former member of the Association be established by the House of Delegates without the previous consent and endorsement of the delegation of the state association of which the proposed beneficiary is or was a member."

REGARDING THE EFFECT ON MEMBERSHIP OF REMOVAL TO ANOTHER STATE

Adopted by the House of Delegates at Minneapolis, Minn., June 18, 1913

"*Resolved*, That nothing in Section 3, Chapter VIII of the By-Laws (Effect on Membership of Removal to Another State) shall be construed as exempting

any member of the American Medical Association from compliance with the requirements of the civil laws of the state or district into which he may have removed."

THE COUNCILS AND THE HOUSE OF DELEGATES

Adopted by the House of Delegates at Atlantic City, N. J., June 4, 1912

The House of Delegates extends the courtesy of the floor to the members of the various councils of the Association, and especially requests the secretaries of these councils to attend the sessions of the House, according them the privilege of the floor, in order that the House may be constantly in position to obtain information concerning work that is being done by these councils, that this body may direct these activities.

RULES FOR THE GUIDANCE OF THE COMMITTEE ON CREDENTIALS

Adopted by the House of Delegates at Atlantic City, N. J., June 6, 1912

1. Credentials shall be of two parts. The first part shall be sent to the office of the Secretary of the American Medical Association by the secretary of the constituent association, not later than seven days prior to the first day of the first meeting of the House of Delegates, and shall be a list of delegates and alternates for that association. The constituent associations shall designate an alternate for each delegate, who may take the pledge of the delegate when authorized to do so by said delegate in writing. In the absence of such authority, any alternate who

has been duly chosen by the constituent association may be seated in place of any delegate who is unable to attend, provided he presents proper official authority from said association. A certificate signed by the president or secretary of the constituent association shall be deemed legal authority (*as amended June 7, 1921*).

2. Each delegate shall be furnished with a credential by the secretary of the association by which he is elected on a prescribed form furnished by the Secretary of the American Medical Association, which shall give the date and term for which he was elected and who was elected to act as alternate for him in case of his inability.

3. A delegate, on presenting himself to the Committee on Credentials, may be seated even though he may not present part 2 of his credential, provided he is properly identified as the delegate who was elected by his association and whose name appears on the Secretary's record.

4. No alternate may be seated unless his credentials meet the same requirements as designated for the delegate and he can show written evidence that he is empowered by his delegate to act for him, except as provided for in Section 1 as amended (*as amended June 7, 1921*).

PROCEDURE IN PREFERRING CHARGES

Adopted by the House of Delegates at San Francisco, Cal., June 22, 1915

The Secretary of the American Medical Association shall file charges with the Judicial Council against Fellows of the Association when overt acts

on the part of such Fellows, supported by reasonable evidence, are brought to the attention of the Secretary of the American Medical Association.

RULES FOR THE GUIDANCE OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Adopted by the House of Delegates at New York, June 7, 1917. Revised at Atlantic City, June 10, 1919.

1. The term "unit" shall signify a single meeting of a section at an annual session.

2. The sections of the Scientific Assembly shall be limited at each annual session to the maximum number of three units.

3. The sections shall not hold more than one meeting on each of the days of the annual session during which section meetings are held.

4. The Council on Scientific Assembly shall apportion the morning and afternoon units at each annual session to the several sections.